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Michigan's Long Term Care Work Group

# Report and Recommendations

June 2000

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## Long Term Care Innovations: Challenges and Solutions

*Michigan Department  
of Community Health*



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*John Engler, Governor  
James K. Haveman, Jr., Director*

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To interested parties:

We are pleased to present this report from the Long Term Care Work Group. It represents input and perspectives from literally hundreds of consumers and family members, from providers and advocacy groups throughout the state. This report addresses the needs of adults with disabilities and the elderly in a positive and innovative fashion and will serve as a model to the nation. This report is both an end and a beginning. It is the end of an intense period of study and deliberation to generate this report. It is the beginning of a process of moving toward implementation of the concepts and directions contained here. We want to continue the dialog with all affected parties as we move toward implementation and welcome your continued input and questions. Please forward your input to:

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This report will be available on the Department of Community Health's website: <http://www.mdch.state.mi.us>. Copies can be downloaded or requested from the address above.

We have enjoyed this opportunity for partnership between the Michigan Legislature and the Department of Community Health. The energy and enthusiasm brought by each member contributed to the success of this effort.

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James K. Haveman, Jr., Director  
Michigan Department of Community Health

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## **Executive Summary**

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Significant increases in life expectancy, a growing elderly population, and advances in medical technology are setting the stage for long term care challenges in the 21st century for Michigan and the rest of the nation. It is imperative that Michigan plan for the future of long term care in order to meet the needs of future generations who will depend upon public resources for some or all of their care.

The Michigan Long Term Care Work Group is comprised of two Senators, two members of the House of Representatives and four officials of the Michigan Department of Community Health. The Work Group is chaired by James K. Haveman, Jr., Director of the Department. It began its work in late March of 1999. It received input from a broad range of people involved in the long term care system who shared their vision for an improved system. The work group adopted a set of guiding principles for its work in redesigning the long term care system and from input received, identified key themes for its deliberations. The guiding principles and the key themes provide the framework for the recommendations of the work group.

The Work Group issued a Preliminary Report and Recommendations in September 1999. It included a broad range of recommendations. Public input and testimony on the Preliminary Report was received in writing, via fax and internet and through nine public hearings held throughout the state. After review of that input and its own further deliberations, the Long Term Care Work Group is now issuing its Report and Recommendations.

This Report of the Michigan Long Term Care Work Group includes recommendations in the areas of quality of life and quality of care, personal responsibility, living independently, eligibility, nursing homes of the future, and organized systems of care. These recommendations are expected to make incremental improvements in Michigan's long term care programs and services. The report recommends the establishment of four different long term care models as a means of providing integrated and coordinated services to eligible individuals. Adults who need long term care typically fall into one of four groups: adults with disabilities, frail elderly, people with Alzheimer's disease and related dementias and people at the end of life.

## **Quality**

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Quality of care and quality of life are essential to any improvement of the long term care system. Recommendations for expanding consumer choices within the Medicaid long term care program, providing incentives for people who go into the long term care field and reducing turnover and absenteeism for long term care workers are addressed. Developing practice guidelines and assistance for long term care facilities to be able to successfully care for people who have behaviors that are disruptive or involve the abuse of other residents are also addressed.

## **Personal Responsibility**

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There are a variety of ways that Michigan residents can plan and provide for their own and their family's long term care needs. At the present time few people actually do so. Michigan's Insurance Commissioner reports that fewer than 2.5 percent of Michigan's citizens have purchased long term care insurance. The Work Group recommendations include a broad-based public education campaign to educate Michigan citizens about their potential need for long term care services and the need for individuals to make plans to pay for this care including the purchase of long term care insurance.

Care from spouses, relatives, friends and neighbors represents the bulk of services provided to persons who need long term care. The Work Group has recommended added supports for family care-givers including a significant expansion of respite care.

## **Living Independently**

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Housing is an essential part of any solution to long term care. A first priority must be a focus on helping people who already have a place to live to keep their housing and be able to receive care there. The development of a collaborative plan between the Michigan Department of Community Health and the Michigan State Housing Development Authority that expands publicly supported housing for adults with disabilities and the elderly is also a priority.

## **Financial Eligibility**

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Many people think of public financial support, including Medicaid, as an entitlement. They take every possible opportunity to transfer their assets in order to qualify for public support without spending their assets on their care. The Work Group supports closing all loopholes for asset transfer by middle and upper income individuals to assure continued availability of public support for people without other alternatives.

## **Nursing Homes of the Future**

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The nursing home resident of the future will have significantly different characteristics than today's nursing home resident. Medical advances, shifts in treatment practices, financing and public policy will all have an impact. Projecting the characteristics of the nursing home resident of the future will help the nursing home industry successfully prepare for these changes.

## **Organized Systems of Care**

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Michigan's current long term care system does not focus enough on prevention and early intervention, is not consumer driven, lacks a clear point of entry and has limited choices.



Existing services are not integrated into coordinated systems of care. There are no incentives for planning and use of private resources, and dual public funding streams (Medicaid and Medicare) create confusion and impede efficiency.

Other states have addressed the financing and delivery of long term care in a variety of ways but typically have implemented a single model of care. Our intention is to initiate four different approaches in selected areas of the state. Replication of the Program for All-Inclusive Care for the Elderly (PACE) will be encouraged as a component of each of these four approaches. Information about long term care services and eligibility assessment will be performed by MI Choice Access.

### **MI Choice Access**

When individuals and families need to consider long term care, either as a result of the aging process or as the result of a long term physical disability, it is often difficult to know where to go for information about the options and resources available. Knowing options and resource strategies as early in the planning process as possible, will allow people to use their own and other private resources as wisely as possible. Assuring information about long term care is readily available, necessarily includes assisting people in accessing needed services and supports. This will be done through the MI Choice Access system.

### **Long Term Care HMO**

This model seeks to integrate acute and long term care by delivering those services through Health Maintenance Organization (HMO) structures. The HMOs will have contracts with Medicaid and may also have them with Medicare. Over the last decade HMOs have become a dominant service delivery mechanism for primary and acute medical services. The HMO model has also been applied to long term care and behavioral health services in a few states. HMOs receive a fixed payment to deliver all health services. This assumption of risk and responsibility for care creates incentives for the organization to be efficient, to closely manage care, and to provide preventive care. Market competition creates incentives for HMOs to provide high quality and value-added services. Adding long term care to the medical services maintains the incentives for medical care but also creates incentives to manage the long term care services better and to coordinate care across the different care settings.

### **Regional Provider Organization (RPO)**

The Regional Provider Organization (RPO) is a partnership among multiple provider organizations to form a single, integrated service delivery system. It applies managed care principles of risk and capitation to a provider-driven alliance. The model uses a community-up design strategy, building upon the population to be served and the provider structure that exists within the defined service area. It allows the flexibility necessary to accommodate changing community needs, recognizing that one size does

not fit all. Each RPO will be distinct in its organization, adjusting the partnership as necessary to meet the changing needs of its customers. Participating organizations might include: area agency on aging, centers for independent living, skilled and/or basic care nursing facilities, primary care physicians, hospital systems, local health departments, home care agencies, community mental health services programs, assisted living residences, and other community organizations as deemed appropriate. For example, the model could unite an area agency on aging case management program with home health care providers and nursing facilities, or all long term care providers and a hospital, a physicians clinic, a health department, a mental health provider. Its development is fluid. The model is community based, built upon existing resources in a community but assuring a comprehensive array of services.

### **Virtual Organization (VO)**

Virtual organizations are fast emerging as a basic way to do business. The virtual organization is characterized by electronic communication linking together components of a corporation, or partner corporations, to respond to market opportunities. A virtual organization does not need to own all parts of the business organization to meet a particular market demand. It can add parts through contract, agreement, and electronic linkages. Advantages of the model include great flexibility and partnerships and work arrangements that are not bound by geographic considerations. The virtual organization can also provide instantaneous information on customer needs and service capacity. Local agencies and businesses that will form the basis of the virtual organizations will need infrastructure development support and ongoing technical assistance.

### **Care Coordination Model (CCM)**

The Care Coordination Model represents an evolution of the Medicaid Waiver component of MI Choice into a fully developed long term care model. The model integrates care through collaborative, team-based planning and monitoring. It unites acute/primary health care and community or facility-based long term care into a single integrated package. The model builds upon the existing long term care infrastructure, which has evolved in Michigan through the Medicaid Waiver Program.

### **PACE**

Further replication of the Program for All-inclusive Care for the Elderly (PACE) will be encouraged within the context of each of the four models for integrated care. The PACE model is recognized by the Health Care Financing Agency and includes a full integration of Medicaid and Medicare Funds for dual eligible frail elderly age 55 and over.





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## **Part I: Process and Principles**

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# Long Term Care – A Growing Imperative

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## Demographic Changes

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Significant increases in life expectancy, a growing elderly population, and advances in medical technology are setting the stage for long term care (LTC) challenges in the 21st century for Michigan and the rest of the nation. It is imperative that Michigan plan for the future of long term care in order to meet the needs of future generations who will depend upon public resources for some or all of their care.

In the next few decades the number of adults with disabilities and the elderly populations will dramatically grow, as the nation's 77 million baby boomers move into their senior years. Here in Michigan, the fastest-growing component of persons who may need Medicaid for their long term care support is the non-elderly disabled. These are people who are living longer lives due to advances in medical technology but who require support services to cope with chronic health conditions and functional limitations. Much of the financial responsibility to provide these services will fall to state government and future taxpayers.

Additionally, those 85 and older are the fastest-growing segment of the population. Half of those 85 and over will need help with the basic activities of daily living, and recent studies indicate that nearly half of the 85+ age group will have dementia. According to the United States Bureau of Census, the estimated growth from 1990 to 1996 of the 85+ population was nearly 23 percent compared with only 6.4 percent growth for the total population. In Michigan, the 85+ population will increase by approximately 60 percent over the next quarter century.

## State Funding Through Medicaid

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Long term care services and financing are currently fragmented and at times difficult to access and coordinate. The same individual is often subjected to different and often inconsistent assessments and processes in similar, related, or overlapping services.

Without changes, Medicaid will be unable to support future long term care needs without severely limiting the state's ability to fund other necessary programs. Medicaid is now 20 percent of Michigan's total budget. Without action now the future cost of Medicaid will grow rapidly, primarily because it is the only source of public funding for long term care for low-income individuals and families. Medicaid's original purpose – a program to cover the medical needs of women, children.

Today 71 percent of the funds serve elderly or disabled persons. The elderly account for 22.7 percent of the program expenditures and the disabled account for 48.3 percent. These expenditures are disproportionately high, since the elderly and disabled only comprise 27.6 percent of eligible persons. If these trends continue, long term care as we know it today is not sustainable. With the continued aging of the population in Michigan new initiatives are needed.

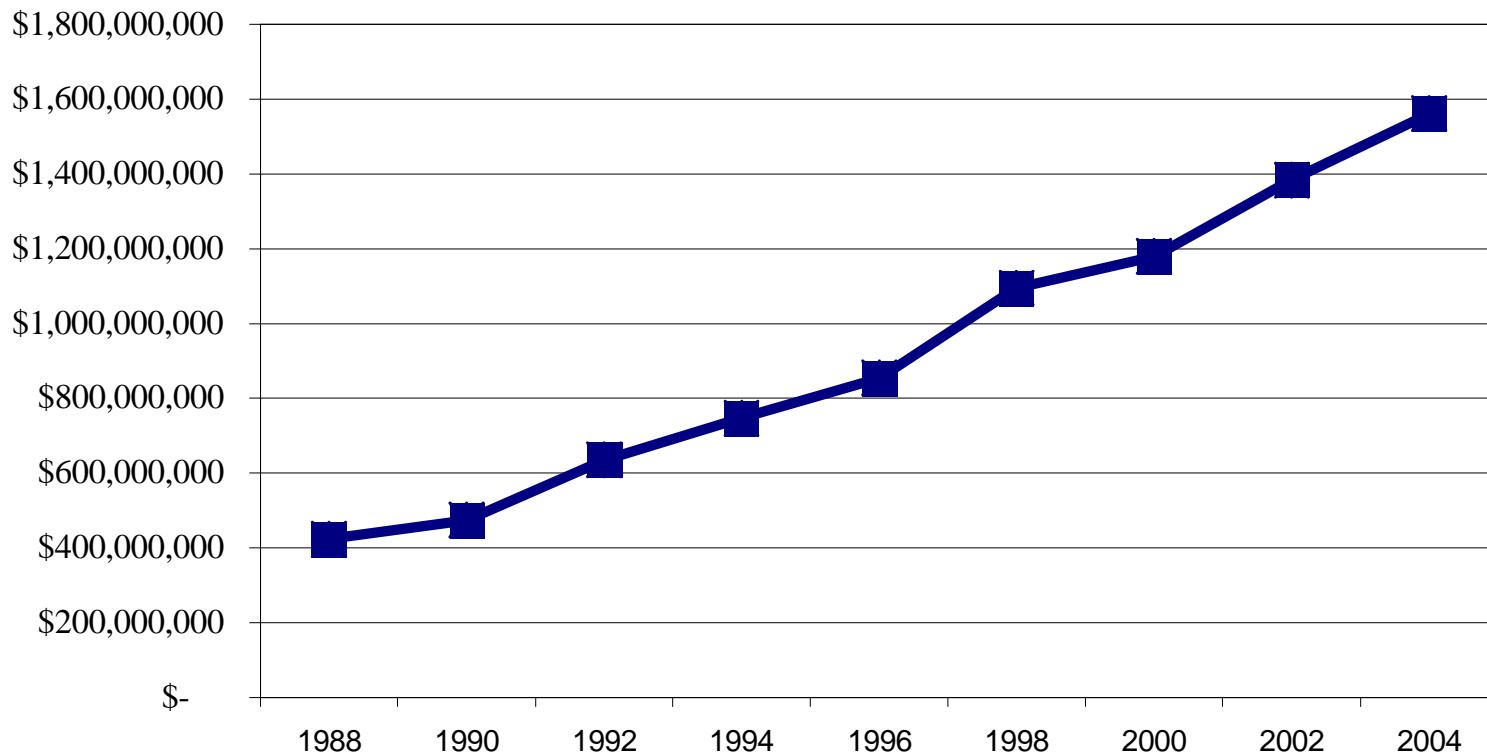
## **The Olmstead Decision**

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In *Olmstead v. L.C.* (1999) a divided U.S. Supreme Court ruled that the Americans with Disabilities Act supports a claim by individuals in institutional settings to be served in community based settings where appropriate. Michigan has a long and proud history of providing services to people with disabilities in community based settings. The programs and initiatives envisioned by this long-term care initiative will further the goal of serving the aged and adults with disabilities in the least restrictive setting possible.



# Michigan Medicaid Long Term Care Combined Accounts: Expenditures and Projections



	1988	1990	1992	1994	1996	1998	2000	2002	2004
Expenditures	\$423,621,399	\$474,492,576	\$634,455,403	\$746,555,732	\$854,571,382	\$1,094,947,821	\$1,179,131,300	\$1,383,470,720	\$1,560,534,278





## **Long Term Care Workgroup**

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In March of 1999 The Michigan Long Term Care Work Group was established. Its members, listed below, were appointed by Chuck Perricone, Speaker of the House of Representatives; Dan DeGrow, Senate Majority Leader; and James K. Haveman, Jr., Director of the Department of Community Health.

### **Work Group Members**

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James K. Haveman, Jr. Director, Michigan Department of Community Health, Chairperson  
Lynn Alexander, Director, Office of Services to the Aging  
Representative Sandy Caul, 99th House District  
Senator Joel Gougeon, 34th Senate District  
Carol Isaacs, Deputy Director, Michigan Department of Community Health  
Representative Marc Shulman, 39th House District  
Robert Smedes, Deputy Director, Michigan Department of Community Health  
Senator Alma Wheeler Smith, 18th Senate District

### **Long Term Care Work Group Process**

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The work group began meeting in late March 1999. Over the course of the next 14 months, it met over 20 times and held nine public hearings on its Preliminary Report and Recommendations. It received input from a broad range of stakeholders in the long term care system. Hundreds of people presented information to the work group and shared their vision for an improved long term care system. In addition, background information was developed and presented by Department of Community Health staff. The work group adopted a set of guiding principles for its work in redesigning the long term care system. From input received, the work group identified key themes for its deliberations. The guiding principles and the key themes provide the framework for the recommendations of the work group.

This report with recommendations reflects the input from stakeholders and the deliberations of the Long Term Care Work Group. The issues addressed here are complex and ongoing. Therefore, this report represents a beginning, not an end. It is the hope and intent of the Work Group that there will be periodic reviews and updates of this report, so that it reflects changes that occur as this effort goes forward, continued input is received and we learn from our initial efforts.

Larry Grinwis, Senior Consultant with the Ashland Group was retained by the Department of Community Health to facilitate and direct the planning process and serve as staff to the Long Term Care Work Group.

## **People With Long Term Care Needs**

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This report and its recommendations are directed at adults who are in need of long term care services and supports. It does not include people who are served through the Medicaid behavioral health carve-out.

Each individual's needs are unique. However the population of adults with disabilities and the elderly can generally be broken into four primary groups. There are commonalities in their need for supports and services. However there are also distinct differences in these groups. The four groups are adults with disabilities, the frail elderly, people with Alzheimer's and related dementia, and people who are at the end of life.

Medicaid support is limited to those who meet both the financial and level of need criteria for long term care. One important objective of the Long term Care Work Group, however, is to create integrated service delivery systems at the local level that allow the integration of multiple revenue sources, including private pay, to provide a comprehensive long term care service system that can serve a broad range of people. This includes people who do not meet the financial criteria for Medicaid as well as those who have less serious care and support needs.

It is also necessary and desirable to integrate long term care supports and services with acute/primary medical services so that all aspects of the individual's care are coordinated together. The two need to compliment each other, not work separately. It is the objective of the long term care models described later in this report to fully integrate Medicaid long term care and Medicare acute/primary care.

### **Adults with Disabilities**

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In Michigan this is the fastest growing group of people who qualify for long term care and supports through the Medicaid program. At the end of FY 99 20 percent of people enrolled in the home and community based waiver program were under the age of 65.

It is important that the organizations that manage the coordinated service delivery models that will be established recognize and understand that people with disabilities who are not elderly have distinctive special needs and desires. This is a population that has often become trapped in nursing homes due to some break-down in their community living situation. People who are younger are often interested in employment options even though they will need on-going supports and services. Assistive technologies are critically important to support these individuals in being as independent as possible. Some may require personal care assistants as well. In general, this is a group of people who tend to be more interested in self-managing and directing their care. They also have an interest in being actively involved in work, school and/or community activities.

The duration of support for adults with disabilities is often life-long

## **Frail Elderly**

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Elderly people who do not have Alzheimer's or dementia disorders but who need assistance with activities of daily living and/or have significant healthcare needs is the third group of people included in long term care.

Understanding the needs and desires of this group is essential as well. Since they do not have cognitive impairments, people in this group are better able to participate directly in the development of their plan of service and to directly represent their goals and desires. It is also important to recognize the need for social supports along with medical care for this group as they often live by themselves and can be isolated from interactions with others.

## **Alzheimer's and Dementia Disorders**

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According to experts at the University of Michigan there are 162,000 people in Michigan with Alzheimer's disease. 250,000 are affected if those with related dementia disorders are added. Research has demonstrated that nearly 50 percent of those receiving nursing home care have Alzheimer's disease and two-thirds have some form of dementia.

Everyone with Alzheimer's disease will require long term care. On average, Alzheimer's disease lasts 10 years but it may last considerably longer. Families provide most long term care for individuals with Alzheimer's disease at home. However, after eight years of symptoms, a majority need out-of-home care of some kind. Providing supports to families has a direct impact on the length of time they are able to provide care for individuals with Alzheimer's and related disorders at home. It is important that the coordinated service delivery system models have the capacity to recognize and treat Alzheimer's disease early and provide supports to family caregivers.

Medicaid will remain the "payor of last resort". However, it is in the financial interest of the state and the managing entity of the coordinated service delivery system model to provide this early identification and caregiver support to people not yet eligible for Medicaid. Doing so can delay the initiation of the out-of-home phase of care since that is where many people exhaust their personal resources and become Medicaid eligible.

There are effective drug, environmental and social interventions that can delay the need for out-of-home care for people with Alzheimer's disease. This makes early identification and intervention very important.

It is also important to acknowledge that some people with Alzheimer's disease and related dementia present significant problem behaviors in long term care facilities. Special intervention is needed to provide proper diagnosis and assessment in order to prescribe appropriate and effective interventions or environments with staff skilled to provide person centered care.

## End of life

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Fewer people die today in acute care facilities. This trend will continue as people increasingly choose to die at home from incurable diseases and as nursing homes and other long term care facilities lower their rates of hospital transfer for residents. There is a growing tendency for individuals and their families to choose a peaceful death “at home” rather than in an acute care facility.

Early identification of people who are at the end of life and linkage with hospice and palliative care is important. The recent report of the “Michigan Cancer Control Initiative Action Planning Group” noted:

“Cancer is the second leading cause of death in Michigan. . . . but the general perception of the hospice community and related medical professionals is that the number of these patients who receive comprehensive end-of-life care—management of pain and other physical symptoms, along with a range of psychosocial and spiritual support services for patients and families—is far less than the number that could benefit from such treatment. National statistics kept by the National Hospice Organization indicate that only 25-30 percent of cancer patients use hospice.”

People with cancer are not the only people who can benefit from earlier linkages to hospice and palliative care. Many people with chronic diseases including such conditions as Alzheimer’s and multiple sclerosis would benefit as well.

## Current Challenges

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As Michigan considers redesigning its long term care system the first question to be answered is, "Why does Michigan need a new long term care system?"

The problems with the current system will become the framework for desirable outcomes in a new long term care system. In identifying current challenges, the perspectives of consumers and their families, providers, administrators, and payers are reflected.

Shortcomings with the current long term care system include:

- Long term care is based on a medical model that focuses on treatment, not prevention
  - The system is not outcome oriented
  - Financing is unnecessarily tied to the treatment setting or service
  - Community-based planning for care is lacking
  - People receiving LTC are segregated and isolated from their communities
  - Quality-of-care and quality-of-life outcomes are unclear
  - Supports for families, who provide the majority of long term care, are not routinely available.
- Long term care is not consumer driven
  - Consumers are not provided the information to make informed choices
  - Consumer choice is limited
  - Consumers do not plan for their possible need for long term care services
- A single point of entry is lacking
  - Present long term care arrangements lack a single point of entry.
  - Access to services is fragmented
- Not all services are integrated into coordinated systems of care
  - Evaluation and assessment are neither comprehensive nor integrated across care settings
  - There are gaps in the long term care services available
- There aren't incentives for the planning and use of private resources
- Dual public funding streams (Medicaid and Medicare) create confusion and impede efficiency
- Financial and regulatory obstacles may hamper change and progress



## Themes

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A consistent set of themes emerged from the input received by the work group. Following is a summary of those themes:

- Quality of life/quality of care considerations need to be included in any future plans.
- Personal responsibility – few people are prepared to handle the expense of long term care.
- Living independently – the services people are eligible to receive often depends on where they live.
- Financial eligibility – current financing is complicated, eligibility is confusing and there is a need to better coordinate Medicare and Medicaid.
- Licensure and regulation – the nursing home industry feels over-regulated without a corresponding impact on quality.
- No organized system of care – the present service delivery system is a collection of separate pieces. There is no front door to the system, no uniform assessment of need and no seamless transition from one treatment setting to another.
- Family support is necessary to assure families can carry out their long term care commitments and responsibilities to care for their loved ones.



# **Guiding Principles for Long Term Care Redesign**

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The Long Term Care Workgroup responded to the list of problems by first developing and then adopting a set of guiding principles that are to guide the planning, recommendations, implementation, monitoring and evaluation of all reform efforts. These principles need to be understood and accepted as critical operational parameters. They are at the heart of all recommendations, as they speak to a profound belief about the value, dignity and contribution of all the citizens of this state, especially and particularly including those individuals with long term care needs and their families.

## **The Guiding Principles are:**

- Consumer-Directed Independence and Informed Consumer Choice
  - Actively involve consumers in need identification, care planning, and collaboration on necessary supports.
  - Enable consumers to make informed choices about their care options through enhanced education and screening.
  - Offer choices that emphasize the consumer's dignity, independence, and quality of life and truly reflect the principles of person-centered planning.
  - Assist consumers in understanding, selecting, and using organized community long term care systems.
- Access
  - Improve medical eligibility determination and enrollment so that it is easily accessible, simple and user-friendly. This includes the concept of no wrong door.
  - Inform citizens about their long term care options, how to access services, the complaint and grievance procedure, and their rights under the law.
- Quality of Care, Quality of Life:
  - Preserve and enhance the quality of life for those needing long term care by:
  - Promoting the ability of individuals to live in the settings of their choice with appropriate services and supports.
  - Monitoring the quality and performance of long term care providers and provide feedback to encourage continuous quality improvement.
  - Regularly seeking consumer input to evaluate the quality of care and the impact it has had on the quality of their life.
  - Supporting consumer report cards – consumer satisfaction, quality, and outcomes for all long term care service options.
- Family and Personal Responsibility

- Support and build the network of family and other informal care-givers in assisting persons with long term care needs.
  - Encourage private and public partnerships to finance long term care services.
  - Create positive models for public emulation of expanded use of private long term care insurance.
- Cost Effectiveness
  - Use the state’s health care dollars to maximize consumer preferences while slowing future budget growth.
  - Use care management and financing strategies to avoid unnecessary expensive care options.
  - Coordinate benefits and financing with Medicare, private insurance, and private consumer resources.
- Minimize inappropriate cost shifting and cost avoidance.
  - Match state resources with personal resources based on a person-centered plan and assessment of each individual’s functional capacity.
  - To create an integrated long term system of care that improves access, choice, quality of care, quality of life, and contains cost.

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**Part II.**  
**Long Term Care Recommendations**

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## Recommendations

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The recommendations included in this section are intended to help individuals and families use their own resources more effectively. These recommendations will also bolster the community infrastructure necessary to assist more elderly and people with disabilities in remaining at home. This can be done in areas such as expanded housing, supports to preserve and strengthen families as they seek to provide care for family members, and elimination of loopholes for those able to financially support their own care.

### Quality of Life/Quality of Care

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The overriding objective in everything proposed or recommended in this preliminary report is to improve quality of life and quality of care for people who need long term care. In addition to improving access to care and supports and increasing consumer choices it is important to take steps to improve the quality of life for those who need long term care. Efforts to do so need to be made in all settings. Capable and competent staff has a direct bearing on quality of care and consumer directed choices have a direct bearing on quality of life.

Quality of care is about the service delivery system itself—the staff, the programs and services/supports---and the care planning process. Quality of care encompasses the various means through which individuals receive the help they need so that quality of life outcomes are achieved. Quality of life outcomes should be the ultimate goal of the long term care models. These are the outcomes in the lives of the people served by a system or a service/support.

Historically systems have had much to say about attempting to produce quality of care outcomes—hence the plethora of policy, rules, regulations and standards. However, carefully crafting the outcomes that truly define quality of care are often absent, so the emphasis becomes “was the regulation followed?”, rather than “was care delivered at a defined level of quality?”. Very little attention has been given to quality of life outcomes—real changes, real achievements, in the lives of real people. Often once these begin to be developed and become a focus, this in and of itself begins to change the way systems and services are delivered, and quality of care is thus improved. These two are very interactive, each influencing the other.

#### **General**

##### ***Recommendations***

1. Require that a person-centered plan be the basis for the services provided to individuals in the long term care system.
2. Implement an incentive payment system for long term care facilities that implements the nursing facility quality indicators such as those under development by the Health Care Financing Administration. Develop/use similar quality indicators for home based care.

3. Develop outcomes and indicators for access, cost, quality of care and quality of life that are consistently evaluated. Use this data in system design improvement, plan/service contracting, etc.
4. Require internal quality improvement systems of all long term care plans and providers.
5. Residential long term care providers should consider designs that provide small home-like groupings of residents.

## **Benefit Design**

All existing benefits or services, including hospice, will be components of the long term care integrated service delivery system models that are described in a later section of this report. This includes all the components of the current Home and Community Based Waiver, Home Help personal care and nursing home care. In addition, all current Medicaid acute care benefits will be included and available to long term care recipients. It will be possible for the long term care delivery systems to add benefits to these minimums, but they will not be allowed to delete any.

One aspect of benefit design relates to the housing settings in which an individual can receive supports and services. Currently, individuals can receive Medicaid financed supports and services in any setting except licensed Adult Foster Care homes and licensed Homes for the Aged. In the proposed long term care integrated service system models, individuals in community based licensed care settings would also be able to receive supports.

It is desirable to bring together multiple resources to provide comprehensive supports for consumers. The approach proposed, however, is to tie services and supports, including housing subsidies, to consumers so that the consumer has the maximum flexibility. Attaching supports and services to a specific facility or residential setting actually limits consumer flexibility and choice.

One component missing from the current broad scope of long term care benefits and services is a community based emergency services component. While the range of current services and supports is quite broad, there isn't any service to respond to consumers when the crisis revolves around community-based resources and supports

### ***Recommendations:***

1. The Department of Community Health should support the intent of HB 4128, a bill to specify contractual requirements for housing-with-services establishments. The bill would require contractual descriptions of services available in the base rate paid by the resident, as well as charges for additional services available through the establishment.



2. If financially feasible, expand the Home and Community Based Waiver program when the current opportunities are full.
3. The Department of Community Health should amend the current interagency memorandum of understanding with the Department of Consumer and Industry Services to allow continuous nursing care in licensed Adult Foster Care homes and licensed Homes for the Aged. This would allow people who meet long term care financial and medical necessity criteria to remain in those homes and receive Medicaid financed supports and services. Allow AFCs or HFAs to provide the home based supports and services as long as the consumer has a choice of providers of those services.
4. New benefits to be included in the long term care models:
  - a. Emergency care-- include a 24-hour, seven days per week, community based crisis emergency service that is prepared to respond to individuals experiencing urgent and emergency situations. Services involve assessments, diagnosis, crisis intervention and/or rapid referral and linkage to needed care and resources. These services include, but are not limited to, outreach, capacity to place an individual in a safe, temporary environment if needed, and immediate deployment of in-home care staff.
  - b. Family/Caregiver support services—includes services provided to families and/or caregivers of persons who are eligible for long term care supports for the purpose of maintaining the person in his/her home. Services include those designed to preserve family and caregiver capacity, prevent facility placement, and restore family/caregiver capacity.
  - c. Include a voluntary option for consumer directed care for the long term care components in each of the models. (This may not be possible in the PACE component.) Implementation of this voluntary option will require the establishment of fiscal intermediaries that provide the necessary administrative fiscal functions to support the consumer in direct control over selecting and supervising direct care workers and other services. These functions may include managing payroll, maintaining records, producing reports, purchasing fringe benefits and other fiscal and support services.
  - d. Allow the long term care model managing entity (HMO, RPO, etc.) to pay room and board costs (as well as other community and housing related supports) in non-nursing home settings at its discretion.
  - e. Allow the long term care model managing entity (HMO, RPO, etc.) to pay for transition expenses such as rent deposits, furniture, etc. to assist those transitioning from nursing home care to community care

## **Long Term Care Staffing**

A comprehensive range of initiatives is needed to create and sustain a pool of direct care workers across all long term care settings. While the scope and focus of this report is limited to adults who have disabilities and the elderly, it is important to recognize that there is a broader range of institutions and agencies delivering services who employ the same direct care staff, primarily nurses and aides. This includes the areas of home health and personal care, hospice, mental health group homes, adult foster care, assisted living, homes for the aged, nursing homes and hospitals. In addition, individual health care consumers, including those who choose to self-direct their care, need an easier way to find qualified, competent direct care workers.

According to the U.S. Bureau of Labor Statistics, over the next decade 600,000 additional direct care workers will be required to meet the needs of a growing population of people who need long term care services. In Michigan, this translates into the need for an additional 24,500 direct care workers. This represents a 32 percent increase in the number of new workers required.

Problems retaining staff are also significant. The Health Care Association of Michigan reports the turnover rate for aides in nursing homes in 1996 was 75 percent. Research indicates that the cost of replacing a direct care staff member averages \$3,000. Turnover costs include nursing pool costs, overtime wages, extra staff time to cover for employee training, employment advertising and interviewing.

This problem is not unique to nursing homes. All sectors of the long term care delivery system, including home health, hospice and others, have significant problems both recruiting and retaining direct care workers and meeting the needs of individual consumers. Comprehensive steps are needed to successfully build a future pool of workers given the current shortage of direct care workers and the growth of the population needing services.

The causes of the problem are multiple. They include: low pay and poor benefits, lack of appreciation for the value of the work, high turnover (which causes short staffing), demanding working conditions and the element of risk involved, lack of control over work product, poor supervision, lack of a career path, an increasing acuity rate of those needing care and a tight labor market. These factors are closely intertwined.

### ***Recommendations:***

#### **♦ Increasing the pool of competent long term care workers:**

1. Initiate a public image campaign to promote working in long term care settings and the role of long term care workers. This effort could be done collaboratively between the Department of Community Health, Department of Consumer and Industry Services, the Department of Career Development and the trade associations representing long term care providers.

2. Through leadership from the Department of Career Development, encourage a collaborative effort between colleges, community colleges, the Department of Career Development and long term care providers to undertake a recruitment campaign aimed at creating a future pool of direct care workers for long term care.
3. The Department of Community Health should work with the Department of Consumer and Industry Services to review and revise as needed the required Competency Evaluated Nurse Aide (CENA) training curriculum to assure it is up to date and reflects the skills required today in all long term care settings. Consideration should be given to a uniform training and certification program that would allow aid-level staff to be trained to work in a variety of long term care settings including home health. Encourage the Consumer and Industry Services Department to continue its Excellence Award program for nursing homes and its quality improvement program awards.
4. Encourage long term care providers and their trade associations to collaborate together to establish a system for comprehensive criminal background checks of direct care workers economically and in a timely manner.

◆ **Retention of long term care workers:**

1. Encourage long term care facilities to participate in the Eden Alternative, the National Association of Geriatric Nursing Assistants or similar programs that have demonstrated a positive impact on staff retention and reducing turnover.
2. Encourage community colleges and others to develop career ladders for long term care workers.
3. The Department of Community Health and the Department of Consumer and Industry Services should work with individual consumers and consumer cooperatives, provider agencies, their trade associations and registered care workers to create the Michigan Long-Term Care Excellence Institute. The institute would focus on developing direct care workers, managers and administrators who work in long term care in order to improve the workplace and enrich work life for all. It would serve as an entity to identify best practices from Michigan and around the country that have had a demonstrated impact on retention of direct care workers.
4. Encourage long term care providers and their trade associations to collaborate together to establish purchasing co-operatives for providing health benefits to full and part time direct care workers.
5. The Department of Community Health should include in its evaluation of the proposed long term care models an evaluation of the practices of staff compensation within capitated systems. It will be important to learn from these practices developed within the greater capitated system whether or not staff wages are impacted positively or negatively.

6. Encourage for profit long term care providers to develop ESOP-type programs to provide an opportunity for employees to become owners to encourage commitment and buy-in and reduce turn-over.
7. The addition of an on-site day care center for children of staff and the community in general can be both a means of attracting and retaining staff, as well as an enriching component of the overall atmosphere for a nursing home. Residents can interact with the children in a variety of ways, providing enrichment to both the children and the nursing home residents. Some existing programs, such as the Grand Traverse Pavillions in Traverse City are already established. Other nursing homes should be encouraged to initiate similar programs.

◆ **Matching available staff with employment opportunities:**

Encourage the establishment of local collaborative efforts to create a registry of available workers and the nature of the employment they seek so employers, including consumers self-managing their care, can be matched together.

## **Individuals who Display Disruptive and Abusive Behaviors**

An estimated one-percent of nursing facility residents may have disruptive behaviors and physically abuse other residents and staff. This understandably results in pressures to discharge them. Unfortunately there are no alternative resources. Many nursing home administrators report that the proportion of residents who have disruptive behaviors and physically abuse other residents and staff has increased significantly in recent years. Development of community-based alternatives for these individuals may reduce the proportion of residents with abusive behaviors in the future.

***Recommendations:***

1. Develop a demonstration project aimed at nursing facility residents who display disruptive behaviors and physically abuse other residents and staff. Intended outcomes include the development of a profile of these residents and develop best practice standards for use by facilities.
2. Convene representatives of the nursing home trade associations and get input from healthcare futurists regarding their research/opinions regarding the characteristics of the nursing home resident of the future.

## **Personal Responsibility**

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There are a variety of ways that Michigan residents can plan and provide for their own and their family's long term care needs. At the present time few people actually do so. The Insurance Commissioner reports that fewer than 2.5 percent of Michigan's citizens have purchased long

term care insurance. Ways to encourage greater efforts by individuals and their families to meet their long term care needs are identified here.

## **Public Education: Planning for Future Long Term Care Needs**

Many Michiganians do not plan for future long term care needs because they have little information upon which to make an accurate assessment of their potential need for long term care services. They have even less information on the array of services and financing mechanisms available to meet those needs. If such information were made available, more people would plan to meet their future needs. This assumption is supported by several studies related to retirement planning.

### ***Recommendations:***

1. The State of Michigan should develop a massive and aggressive public awareness campaign to educate Michigan citizens about their potential need for long term care services as they age. They also must plan to meet these needs. The campaign should emphasize the benefits of starting early to plan and save for future long term care needs. It should identify the options available, including long term care insurance. Even small amounts saved early in life can amount to sizeable amounts at retirement age. The concept of personal responsibility for long term care planning should be emphasized in the public awareness campaign.
2. The State can partner with a variety of local organizations to provide information through existing channels. School systems should be approached to ensure that high school and adult-education life-skills curricula include the subject of long term care planning. The Michigan Model for Comprehensive School Health curricula should also include information on long term care.
3. The internet and other forms of technology should be used to provide information to the public regarding long term care.
4. The State of Michigan should encourage employers to provide pre-retirement education for their employees. In addition to education, employees need access to tools that aid in savings, such as automatic payroll deductions. Small business should be targeted and a consortium approach used to develop models for use in that sector.
5. The Michigan Department of Community Health, in conjunction with the Insurance Commissioner, should provide educational information about long term care and long term care insurance options to the public, including everyone who becomes eligible for Medicare.
6. The Michigan Department of Community Health should promote information about good health practices. People need to know how to identify treatable conditions, including Alzheimer's disease and related dementia, early on and how to maintain maximum functioning throughout their life. Resource guides identifying services

and supports available, including support services for family care-givers, should be available in every county. One example of a collaborative approach to community education is the collaborative between Grand Rapids Community College, Calvin College and key agencies of the Aging Network of Western Michigan. Other examples are the DCH caregiver education initiative and the DCH dementia education network (involving EMU, MSU, U of M and Lansing Community College along with the MI Primary Care Association and other experts in dementia care), and the Dementia Information Network that works through the Parkinson's Foundation, the Huntington's Disease Society and the Alzheimer's Association chapters. Funding for added projects like this should be considered.

## **Family Care Giving**

The care from spouses, relatives, friends and neighbors still represents the bulk of services provided to persons who need long term care. There is no indication that the 80-85 percent of care usually attributed to this source has diminished. Sociological forecasts regularly warn that changes in this country's social and economic situation threaten the stability of this arrangement. As the large majority of women (the traditional source of informal care) enter the workforce, as marital arrangements become more diverse and less stable, and as the birth rate falls (producing fewer children to provide both economic support and direct care), the prospects of continuing to rely heavily on informal care darken. Because of this reality, it is important to develop systematic ways to support caregivers so that financial stress, physical burdens and burnout can be avoided.

Typically care-givers who feel competent persist in care-giving longer and have lower healthcare expenses for themselves than care-givers who do not feel competent.

### ***Recommendations:***

1. Monitor activity at the federal level regarding making home care expenses for a family member tax deductible and consider the impact on the state for similar action.
2. The State of Michigan should identify and encourage replication of best-practice models of community-based collaborative efforts that provide outreach, information, referral, education, respite care and other family support services. Examples include the Dementia Information Network, and the DCH Alzheimer's Demonstration Program. Such best-practice models would identify strategies to reach family members as early as possible in their care-giving career to avoid or minimize crises. These strategies would also promote the efficient use of private resources to provide needed assistance.
3. The State of Michigan should consider expanding the current Senior Companion program, and consider how to develop a similar program for younger disabled adults with priority on those areas where programs don't presently exist.

Replication of local success stories that involve other stipend approaches should also receive high visibility.

4. The Department of Community Health should support the expansion of volunteer resources at the local level. This should be done through existing structures that work with the elderly, non-elderly disabled, hospice, etc. to provide respite care and other family support services to persons providing care for a family or community member.
5. Family respite care should be increased for persons who are not eligible for Medicaid. Reimbursement should be on a sliding scale. (Tobacco settlement dollars have been committed in FY 2000 to implement this recommendation.)
6. Assure that each of the long term care models include a complete continuum of services to support consumers and their family caregivers including care-giver education, respite care, a person centered planning approach and an option for consumer/family directed care through vouchers or similar mechanisms.
7. Promote removable/modular ramps to minimize the cost and maximize support to the largest number of consumers possible.
8. Include use of FIA child day care funds to support families who provide care for parents or adult children.

## **Long Term Care Insurance**

Long term care insurance is one way individuals can protect themselves from the cost of care. Long term care insurance provides its owners with more choices and controls. It also preserves private resources. Most people mistakenly believe they have coverage for long term care through either Medicare or regular health insurance. Most people don't realize the high risk of remaining uninsured. There is about a 1.3 percent probability that an average person will ever use their homeowners insurance and a 2.5 percent probability they will use their automobile insurance. In contrast, there is about a 43 percent probability that a person will receive nursing home services after age 65 and a significantly greater probability they will receive some form of long term care support.

Clearly not everyone can afford long term care insurance, however a 1994 study concluded that for every 1 million long term care policy holders that enter nursing homes, Medicaid stands to save 3.5 to 6.9 billion over the next 25 years.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions that improve the tax status of long term care insurance, especially for employer-paid premiums. Individuals presently hold most policies, but HIPAA may encourage more employer-based coverage. Presently only two to three percent of employers make long term care insurance available to their employees. The current average age of buyers is 69. Long term care policy prices increase dramatically with age

and often deny coverage to the elderly and people with existing handicapping conditions. The adequacy of policies varies widely.

***Recommendations:***

1. Encourage insurers to permit policyholders to use the limits of their long term care policy as a pool of money, rather than a daily benefit for a fixed number of years. For example, instead of a \$100 per day, three-year maximum benefit policy, it would be viewed as a \$109,500 pool of money. This pool could be spent to allow the benefits to last more than three years. As long as the person did not spend more than \$100 per day, there should be no penalty for seeking alternative care, such as assisted living, to make the benefits last longer.
2. Encourage whole life insurance policies that permit the acceleration of death benefits for long term care expenses.
3. Design a standard set of long term care insurance policies with a standardized definition of long term care benefits for policies made available by insurers. These would contain the type of benefits that would have the greatest interest for the emerging markets. This will provide consumers an opportunity to seek the most competitive rates and services available. This would ideally be a national campaign to promote long term care insurance. The National Association of Insurance Commissioners (NAIC) may be the appropriate organization to work through to adopt this idea.
4. Monitor federal activity regarding making long term care insurance premiums deductible like regular health insurance and consider the impact on the state for similar action.
5. Develop a consumer guide to assist people in comparing/selecting a long term care policy. Develop report cards for long term care policies and their carriers.
6. Work with the Michigan Office of the State Employer in formulating an optional long term care program for state employees.
7. Use the Insurance Bureau web site to provide a link to long term care information.
8. The Insurance Bureau will build on its relationship with the Office of Services to the Aging (OSA) by assisting them with updating program materials and the educational programs that OSA conducts at senior centers across the state.

## **Living Independently**

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Housing is an essential part of any solution to long term care. The interaction among housing options, benefits and personal responsibility has a causal relationship to specific health outcomes. For many people, this leads to outcomes that are unnecessarily expensive, restrictive and diminish the quality of life.



Studies of the preferences of individuals who have long term care needs clearly indicate the preference to stay in their own homes rather than almost any other choice, including moving in with family, assisted living, nursing home, and other options. The difficulty of remaining in their own homes can be due to a variety of factors. Sometimes nursing homes become the only option where an individual who does not have a home and has exhausted their resources can receive care and have their room and board costs paid.

***Recommendations:***

1. The first priority in housing needs to focus on helping people who already have a place to live to keep their housing and be able to receive care there. This can be accomplished through home care, supports for family care-givers, and expanding the set of living environments where individuals can receive home care supports and services. Each of these is addressed in other areas of this report. Helping people be aware of resources and strategies such as reverse mortgages is important as well.
2. In addition to these strategies it is desirable for the Department of Community Health in conjunction with the Michigan State Housing Authority and other applicable entities to develop a plan for expanding publicly supported housing for the adults with disabilities and elderly throughout the state. This plan (to be completed by September 30, 2000) should emphasize the following:
  - a. A consumer focus rather than a provider focus. Qualifying consumers need the maximum amount of flexibility to use housing supports and long term care supports and services to live where they want to live. Consumers should not be required to live in a specific setting in order to be eligible for either housing supports or long term care supports.
  - b. Consumer directed voucher-like approaches for the purchase of non-traditional services and supports.
  - c. Models like the MSHDA financed congregate housing where services are available on an a`la carte basis and could be purchased by residents with service vouchers.
  - d. Existing rules and regulations need to be reexamined to assure they are consistent with new directions and policy.
  - e. Expanded options for ownership.
  - f. Strategies for increasing HUD vouchers and coordinating with the home and community based waiver program and the initiation of the long term care models.
3. Analyze the impact of exempting from property tax the cost of modifications required to make the home accessible to an elderly or disabled family member who would otherwise need a nursing home. (It should be noted that MSHDA finances

barrier-free improvements to single-family homes through its Home Improvement Loan Program at low interest rates.)

4. Consider mechanisms to phase in elements of universal design, e.g. modify the State building code that make homes accessible to persons with disabilities. First elements phased in could deal with wheel chair ramps and accessible bathrooms. In addition, federal guidelines for design standards for housing units designed for four or more families should be reviewed.

## **Financial Eligibility**

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Issues related to eligibility fall into two general areas. The first relates to eligibility for Medicaid to provide financial support for individuals who are in need of long term care supports. Presently, financial eligibility is confusing. The level of income an individual is allowed in order to qualify for Medicaid is different depending on the actual service received. For example, the income level for a person in a nursing home is significantly less than the allowed income for a person receiving Home and Community Based Waiver Services. However, people who receive nursing home care are allowed to “spend-down” to the income level; people receiving waiver services are not.

The second aspect of eligibility deals with medical necessity eligibility for long term care. Some of the suggested models for an organized service delivery system for long term care call for integrating into one service delivery system revenues from multiple sources, including self-pay. In these instances there is an important distinction between medical necessity eligibility for long term care supports and financial eligibility for Medicaid financial support. The former is broad and covers all available revenue sources. The latter is narrow and limited to Medicaid.

### **Divestiture of Assets**

Many people think of Medicaid financial support as an entitlement. They take every possible opportunity to transfer their assets to protected status or to their heirs in order to qualify for Medicaid support without spending their assets on their care. Medicaid was established to provide support for those with no assets and no other options. In order to preserve the availability of Medicaid for the truly needy it is necessary to assure that those who can afford to pay for their own care are not able to creatively divest their assets in order to qualify for public support.

There are legal means that people can use to protect their assets so they are not required to spend everything they have in order to receive support from Medicaid. Two general means are available – purchasing long term care insurance and establishing legal trusts.

Medicaid does not include the value of a home when determining eligibility. One can own a home and still get financial support in a long term care setting if one meets all other eligibility requirements. However, some people sell their home and wind up with a large cash asset, which Medicaid does consider when determining eligibility. These

people will probably not qualify for Medicaid support. People need to be aware that this and other financial activity may affect their Medicaid eligibility.

When a spouse dies most pension plans, including social security, reduce the payment to the surviving spouse. Often this reduced level of income makes it impossible for the surviving individual to stay in their home.

***Recommendations:***

1. Expand the state's educational and public information efforts regarding Medicaid eligibility criteria so people will not unknowingly take actions that make them ineligible for long term care support.
2. Seek authorization from the Health Care Financing Administration to have uniform financial eligibility criteria for all long term care services and include the ability to "spend-down" for all long term care services.
3. Support closing all loopholes for asset transfer by middle and upper-income individuals.
4. Recommend state legislation specifying that state pensions to the surviving spouse will not be reduced. Encourage the federal government to take similar action relative to social security and federal pensions.

**Subrogation**

Medicaid is a payer of last resort and entitled to recovery of costs incurred when there is another source of payment (private insurance coverage, medical malpractice award, no-fault insurance award, etc.) Michigan attempts to recover funds from third parties who are liable for expenses incurred by the program. The state is often unaware of suits that would result in the award of funds to which the state would have claim.

***Recommendation:***

- Enact legislation that would contain mechanisms, including possible incentives to attorneys who notify the state of lawsuits in which Medicaid may have an interest.

**Senior Fraud**

Seniors and others with long term care needs can be vulnerable to fraud and attempts to divert their assets to others, including relatives.

***Recommendation:***

- The recommendations of the Governor's Work Group on Elder Abuse/Adults at Risk of Exploitation, chaired by the Family Independence Agency, should be considered when that report is released.

## **Partnership**

The present system for Medicaid eligibility is largely an all-or-nothing system. In order to qualify for Medicaid support an individual must either be impoverished or divest of their assets in order to qualify.

The Partnership for Long Term Care, initiated under a Robert Wood Johnson Foundation grant, called for public-private partnership to overcome the requirement to impoverish oneself to qualify for Medicaid. Partnership projects were funded by RWJ as a public-private alliance between state governments and insurance companies. The purpose was to combine more affordable long term care insurance with special Medicaid eligibility standards that could better protect against impoverishment. Under this program, an individual could have the value of his or her assets waived for Medicaid eligibility determination up to the amount of the insurance policy. However, new HCFA standards only allow the asset protection provisions to be in effect while the insured is alive. This prevents states from using this waiver. Instead it requires states to recover the individual's assets after their death.

A second area where some limited partnership is possible is in the area of trusts. The Omnibus Budget Reconciliation Act 93 (OBRA) allows three exceptions in which a trust can be created and assets converted from countable to not countable. Typically these exceptions allow funds to be placed in the trust only for the cost of care that is not covered by Medicaid or Medicare. The value of the trust will not affect Medicaid eligibility. Assets remaining in the trust at the time of the death must be used to reimburse the state for any Medicaid expenditures it has made.

### ***Recommendations:***

1. Michigan should develop a program that encourages a partnership between public and private resources and is not punitive.
2. Promote information about using long term care insurance or legal trusts to protect assets.
3. Seek Medicaid block grant from Health Care Financing Administration (HCFA) to allow Michigan the freedom to coordinate Medicaid and private funds.
4. Encourage the Governor and Legislature to recommend that Congress repeal OBRA 93's provisions which prohibit a state from establishing a partnership program where assets would be protected from estate recovery if they purchased a long term care insurance policy.

## **Nursing Homes of the Future**

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The nursing home resident of the future will undoubtedly have significantly different characteristics than today's nursing home resident. Speculation can be made about some of those

changes. Medical advances will undoubtedly result in the nursing home resident of the future being much older even though the length of their stay will probably be shorter rather than longer.

Other possible impacts from medical advances are more speculative. The possibility of a cure for Alzheimer's and other dementias through gene therapy would significantly reduce the number of people with dementias in nursing homes. The absence of such a cure will probably result in a significant increase in the proportion of individuals with dementia who require 24 hour residential care.

Shifts in treatment practice and financing will also impact nursing homes. Sub-acute care for people recovering and receiving rehab for surgery, falls and fractures, etc. is expected to increase in the future.

Public policy will also impact the characteristics of the nursing home resident of the future. There has already been a decline in nursing home occupancy, largely due to the private pay consumer selecting alternatives including home care and assisted living. Shifts in public payment policies could have similar impacts.

All of these factors and others add up to the possibility if not probability of significant changes in the characteristics, and potentially the numbers of nursing home residents in the future.

Stand alone nursing homes may be less desirable in the future and many people prefer to go to continuing care retirement communities (CCRC) which offer a continuum of residential options. Expansion of the number of CCRC's in Michigan may have policy implications that will need to be addressed.

### ***Recommendations:***

1. Solicit input from healthcare futurists regarding their perspectives regarding the characteristics of the nursing home resident of the future.
2. Encourage the nursing home industry to prepare its members for changes in the characteristics of their residents to assure they are prepared to effectively care for residents with these characteristics.

## **Organized Systems of Care**

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### **MI-Choice Access**

When individuals and families need to consider long term care (LTC), either as a result of the aging process or as the result of a long term physical disability, it is often difficult to know where to go for information about the options and resources available. Since many more people will be approaching this need in the future, it becomes increasingly important to make information readily available to all of the citizens of Michigan. Knowing options and resource strategies as early in the planning process as possible will

allow people to use their own and other private resources as wisely as possible. This will also promote the most efficient and effective use of available public funds and resources.

***Recommendation:***

- Implement the MI-Choice Access system detailed in Part III of this report.

## **Integrated Long Term Care Delivery Systems**

The Long Term Care Workgroup has researched what other states have done to create an organized and managed service delivery system designed to improve access to long term care services, increase consumer choice and control costs. From this research the work group has concluded that there is not one clearly preferable approach. It is possible that different models work better in urban versus rural areas. Rather than attempting to select one model and implement it statewide, it makes more sense to try multiple approaches in various settings in this first phase of implementing integrated long term care delivery systems.

Initial contracts for the Phase I models, expected to be initiated in July 2001, will be for a minimum of three years. Phase II, when added model sites will be added, will be initiated October 2002.

In order to promote competition and consumer choice multiple models will be allowed to exist in the same community.

***Recommendation:***

- To initiate phase one of the integrated long term care delivery systems during FY 2001 using four models (Long Term Care HMO, Regional Provider Organization, Virtual Organization, Care Coordination). PACE may be replicated as part of any of the first four models. Implementation level descriptions are provided in Part III of this Report.

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## **Part III: Organized Systems of Care**

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# DRAFT DOCUMENTS

*Descriptions of the MI Choice Access, the LTC models and items in the Appendix represent the information and concepts developed as of May 2000. Revisions are expected with any part of these as the result of new information, further planning processes, additional direction from the Long Term Care Workgroup, input from individuals and families, comment and ideas from stakeholder groups, and negotiation with the Health Care Financing Administration.*

## Michigan's Long Term Care Objective

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The Long Term Care Workgroup developed the following objective to define the outcomes of long term care reform:

***To create an integrated long term system of care that improves access, choice, quality of care, quality of life, and contains cost.***

Each component of this objective has been treated with seriousness and commitment. Early on it was recognized that the system must be integrated in order to achieve the desired improvements. Integration brings together and focuses access and choice. It also provides the context for consistent evaluation of quality of care, as well as the environment in which services and supports can be effectively coordinated to better assure improved quality of life.

Integration includes not only all the services, but fundamentally it is also about funding. Recognizing that public funds are limited, it is Michigan's intent to maximize the effect of all available resources by promoting systems that include multiple public funding streams and public/private partnerships. Bringing available funding streams closer together as the system's foundation supports the most effective and efficient use of dollars possible through more focused resource alignment. Resources can be more clearly understood in terms of their relationships to each other, and to the set of individuals and services each is available to support. Savings in one area can ideally be redirected to other areas of greater need. Only in this way will the growing need for long term care be able to be addressed, now and into the future.

It is important to understand the description of MI Choice Access and the long term care models within the context of the full Long Term Care Workgroup Final Report and Recommendations. The Workgroup understood that serving all the citizens of Michigan and fulfilling its obligation to wisely administer public funds necessarily involves a broad and far-ranging set of strategies. The new integrated systems of long term care that are being recommended are only one of these strategies. They will succeed only so long as they are supported by and linked to the other reform initiatives.

The State's intent is to better prepare all of its citizens for eventual long term care needs by creating an environment in which early planning and decision making enhances and extends individual health and personal resources. For example, early implementation of care and financing options preserve both wellness and financial resources. Inclusion of as many resources as possible will promote flexibility in care planning, and the greater the care planning, the greater the potential for resource utilization efficiency.

Communities are to be encouraged and supported in efforts to collaborate with regard to local resources and the inclusion of people of all ages and disabilities in every aspect of community life. Within this broader context, these models for long term care system integration are about improving access, choice, quality of care, quality of life and cost containment for people who reach the place in their lives where they need long term care.

# **MI Choice Access: A system for improved information, access and choices for consumers**

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## **Introduction**

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When individuals and families need to consider long term care (LTC), either as a result of the aging process or as the result of a long term physical disability, it is often difficult to know where to go for information about the options and resources available. Since many more people will be approaching this need in the future, it becomes increasingly important to make information readily available to all of the citizens of Michigan. Knowing options and resource strategies as early in the planning process as possible will allow people to use their own and other private resources as wisely as possible. This will also promote the most efficient and effective use of available public funds and resources.

## **Access Challenges**

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Assuring that information about long term care is readily available necessarily includes assisting people in accessing needed services and supports, if it is to be effective and helpful. Any improved plan for addressing information and access must address the following current issues and problems:

### **Need for One-Stop Shopping**

People do not know where to go for information about long term care. If they are in need of services, they are subjected to numerous barriers as they negotiate a path through the information, referral and eligibility determination maze. Integrating information and referral, screening, financial eligibility assistance and long term care eligibility determination activities through one visible, easily accessible point of entry reduces fragmentation and improves access for persons seeking assistance.

### **Need to provide unbiased information and referral services so that people can identify and act on their preferred LTC choices**

A common theme among persons seeking LTC reforms is the need to assist families and individuals with good information and referral during a LTC crisis. Providing comprehensive information about long term care options helps assure that families are not inadvertently pressured into making a choice inconsistent with their preferences and values. Good information may also insure that families can stretch their own funds farther by using less costly community options, thus delaying or eliminating the need for extensive public assistance.

### **Need to match resources to people's needs**

There is a need to assure efficiency in the allocation of LTC resources to those in need. LTC consumers need assistance to evaluate their needs and to learn about all the possible supports available. Currently many people receive the service offered by the first organization they call, and in some situations other supports may be more appropriate and less costly.

### **Need to support individuals and caregivers before a crisis situation occurs**

Research from studies in respite care for Michigan families has shown that caregivers are often unaware of the availability of services, and are more likely to seek services during a crisis. This often results in the use of more expensive and less community based interventions. It can be the precipitating factor in a nursing home admission, for example. Had the individual and/or caregiver been aware of the availability of other supports, less duress would occur for the consumer and caregivers, as fewer situations would escalate to the point of crisis. Interventions used sooner are usually less expensive than those used to respond to a crisis.

### **Need to stop/prevent provider ability to avoid the individuals with needs that require more expensive resources**

Presently Michigan allows both its nursing homes and waiver programs to decide who is medically eligible for care. This sets the stage for selecting people who are relatively easier to care for. The present arrangement also creates access problems for people with severe functional limitations or people who exhibit undesirable behaviors.

### **Need to build adequate safeguards for the proposed case mix reimbursement system for the new LTC models**

As individuals are enrolled in a LTC model/plan, each will be assigned a case rate based upon the individual's level of care needs. It is imperative that this case rate assignment be made fairly and by a neutral party.

### **Possible woodwork effect**

Policy makers in Michigan and other states have been reluctant to expand community based long term care options as alternatives to nursing home care for fear of creating demand that would have no end. Arizona, considered by many to be a model for other states, was judged by evaluators to have been successful because it established a disinterested neutral screening entity to assure that all persons served through the Medicaid system meet the same medical eligibility criteria. What this means is that

anyone accepted into community care meets the same criterion as someone accepted into a nursing home.

## The MI Choice Access System

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Given the challenges and issues that must be addressed, a number of functions can be identified that must be performed by an improved information and access process. These are:

1. Information and education for all callers
2. Referral and linkage to appropriate other resources for all callers
3. Request/problem triage
4. Long term care eligibility determination
5. Assistance with Medicaid financial eligibility determination
6. Assurance of informed choice
7. Enrollment in the model or option selected

The MI Choice Access system is intended to serve all citizens who are interested in information about long term care resources, not just people who are potentially Medicaid eligible. Initially the MI Choice Access system will only operate fully in those parts of the state where the long term care models are in operation. Full implementation will be expanded to other parts of the state as models are expanded.

The MI Choice Access system is similar in design to the Medicaid Medicare Assistance Program (MMAP). There are five primary components to the MI Choice Access system. These are:

- Statewide toll free number telephone system
- Local Information and Assistance Centers
- Statewide enrollment broker
- Long Term Care Models
- Department of Community Health centralized administrative management

The starting point for the MI Choice Access system is a single **statewide toll free phone number**. When citizens call this number, they will be automatically routed to a local resource organization, just as occurs with MMAP. A local person in a local organization in the caller's home community will actually answer the phone.

The cost of this toll free phone component is relatively inexpensive. In 1999, the MMAP statewide system fielded nearly 34,000 calls at a cost of approximately \$8,700. Maintaining this telephone system will be the responsibility of the Department of Community Health.

The key local component in the new process will be the **local Information and Assistance Center**. Initially these centers will exist only in the areas where the LTC models are located. Organizations that serve as local information and assistance centers will be selected on a competitive basis. They will be local agencies that are well informed about resources in the community. They will be agencies that are not involved in the management or delivery of Medicaid or Medicare financed services delivered through the models. Examples of organizations that might be interested in functioning as an information and assistance site could be a Center for Independent Living, a local public health department, a Commission on Aging, an Area Agency on Aging, a United Way funded local Help Line, Alzheimer's Association Chapters, etc. It is possible for the local information and assistance center to be a collaborative effort between multiple local agencies.

For those areas of the state that are not initially covered by one of the LTC models, local resource organizations will be designated (through a voluntary application process) as the local long term care information and referral center. These organizations will receive all of the same information and educational materials that are developed for the Information and Assistance Centers. They will receive technical assistance, but will not be under contract to DCH as will the Information and Assistance Centers.

The functions performed by the Information and Assistance Centers will include local information and education about long term care, problem triage, referral to other community resources, and telephone and/or in-person assessments to determine long term care eligibility and determination of level of care need. Individuals, families and referral sources will be educated about the options and choices that are available. Initial linkage with the Family Independence Agency will be made, when appropriate, to determine financial eligibility for Medicaid. Information and Assistance Centers will have specific responsibilities and reimbursement covered through a contract with DCH.

When the person is seeking Medicaid financed long term care services, the information collected by the Information and Assistance Centers will be forwarded, ideally electronically, to a **statewide enrollment broker**. The enrollment broker will verify medical eligibility and, when financial eligibility has been determined, will enroll the individual in the LTC model/plan available in the area.

People will be enrolled in the local **long term care model**. There will be a choice of more than one model in many communities.

Each area that has a long term care model in operation will be covered by all the components of the MI Choice Access system. Other areas of the state will not have available the full range of services through the local LTC Access and Information Center (specifically assessment services), nor will they be involved with the statewide enrollment broker or a LTC model, until such time as the LTC models/plans are expanded to other parts of the state.

DCH will provide a **centralized administrative management function**. This means all Information and Assistance Centers will operate under the same contracts, with consistent information and response protocols. It will also assure that the Department is directly involved in problem solving with the Centers so that an active partnership exists between the State and the

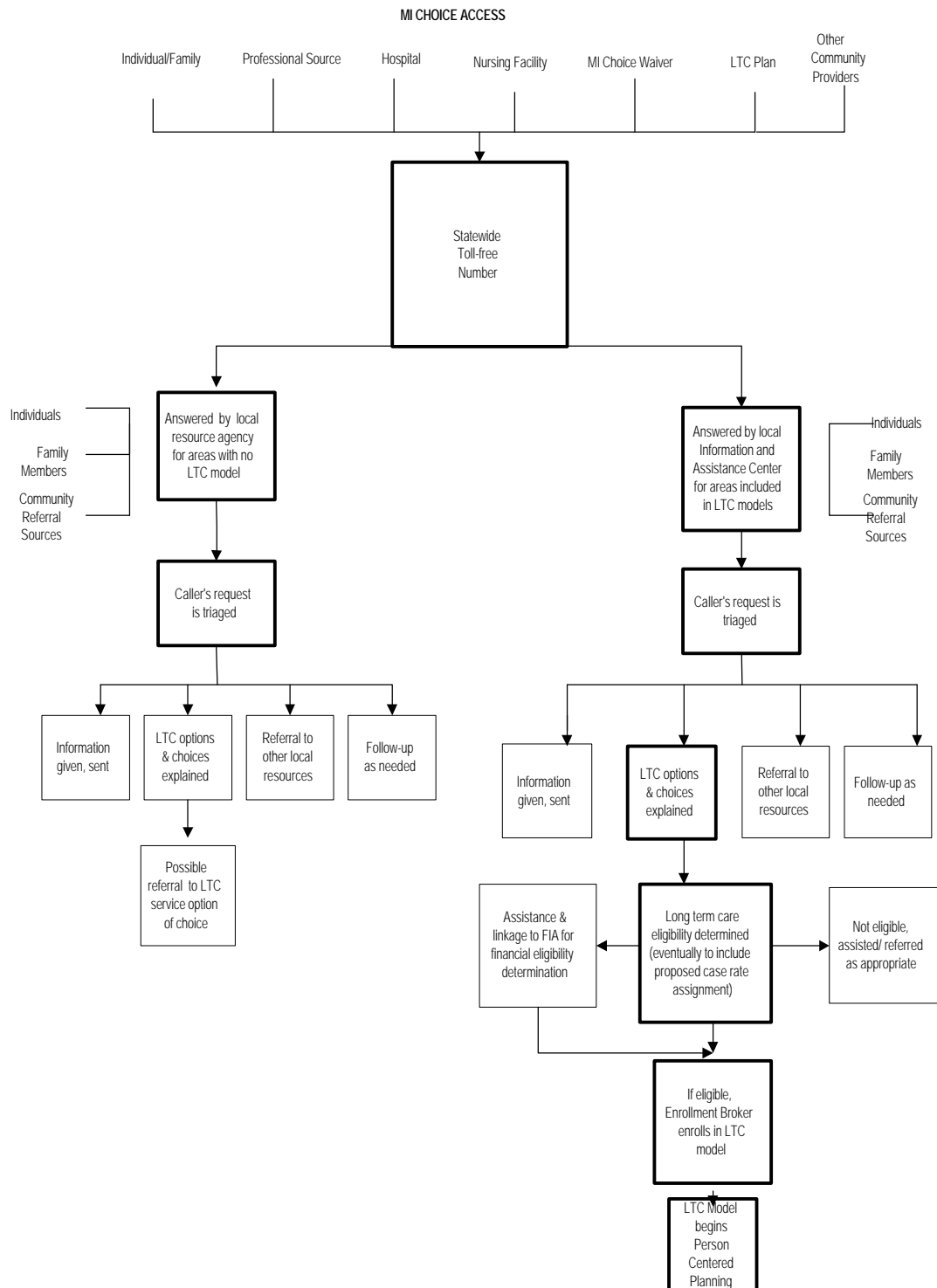
Centers to assure ongoing quality improvement. DCH will also be able to monitor and provide needed technical assistance to the Information and Assistance Centers, as well as to the LTC models/plans also under contract to DCH. Linkage and interface issues between MI Choice Access system components will be directly accessible to DCH for problem resolution and support to all parties involved.

The DCH administrative function will also assure centralized integration of all other LTC reform initiatives and recommendations that are adopted by the LTC Workgroup in its final report. For example, as other statewide information and education initiatives are implemented, DCH will assure that these efforts are implemented through the Information and Assistance Centers. As the collaborative housing plan being developed by DCH and the Michigan State Housing Development Authority is implemented and begins to expand local housing options, this resource information can be fed directly into the local information network.

Evaluation of the MI Choice Access system, and all of its components, including that of the DCH administrative role, is critical. This sequential development of the MI Choice Access system affords the same opportunity for thoughtful expansion, as does the approach being used with implementation of LTC model plans. The external evaluation design and process that will be used with the LTC models will address the outcomes of the MI Choice Access system and process as well.

In summary, the MI Choice Access system will be an effective way to begin to address issues and challenges presently faced by people who want to learn more about long term care and the options and resources available. It will assist the state in better assuring that public dollars are used to support the appropriate options for people who are equitably determined to be eligible for Medicaid LTC services and supports. It provides a balanced approach between centralization to assure statewide consistency and comprehensiveness, and the needed local response to assure accuracy and sensitivity in responding to each individual caller's situation within the context of his or her own community. Finally, it allows the access system to grow gradually, so that problems can be addressed in a manageable and prompt way as they arise. Improvements can be more easily implemented and carried forward with expansion over time.

## MI Choice Access Flow Chart





# Long Term Care HMO

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## I. Introduction to the Model

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### A. Overview

This model will integrate acute and long term care managed care by delivering those services through Health Maintenance Organization (HMO) structures. Over the last decade HMOs have become a dominant service delivery mechanism for primary and acute medical services. The HMO model has also been applied to long term care and behavioral health services in a few states. HMOs receive a pre-paid fixed payment to deliver all health services needed by enrollees. This assumption of risk and responsibility creates incentives for the organization to be efficient, to closely manage care, and to provide preventive care. Adding long term care to the medical services maintains the incentives for medical care but also creates incentives to manage the long term care services better and to coordinate care across the different care settings.

This model would work best if a single HMO were created from which Medicaid long term care beneficiaries would receive all health, medical, and long term care services. However, having a single HMO is complicated by the reality that while Medicaid pays for long term care services, Medicare pays for most of the health and medical services for those in the long term care eligible population. Medicare is a federal program administered by the Health Care Financing Administration (HCFA). One of the requirements of the Medicare program is that beneficiaries have the freedom to choose their providers of medical services. While a Medicare beneficiary can choose to have their medical services provided by an HMO, they can also choose to receive their medical services under the fee-for-service model. The experience of other states trying to integrate medical and long term care is that HCFA has shown reluctance to waive the freedom of choice requirements that could require that beneficiaries receive their health, medical, and long term care services from a single HMO. Because of this, the development of an HMO that provides the Medicaid long term care and medical services in coordination with health and medical services provided by Medicare is the more likely arrangement. Medicaid is always the payor of last resort. The HMO model can be designed to encourage beneficiaries to select the HMO for their Medicare services through incentives. The LTC HMO model is currently being used in the Arizona Long Term Care System, in Minnesota, and in the Texas Star+Plus demonstration project.

The objective of implementing this model is to test if the concepts of managed long term care developed in Arizona, Texas, and Minnesota have applicability in Michigan. Another objective of the demonstration is to measure success in recruiting persons eligible for both Medicare and Medicaid to obtain all of their services from the managed care organization. Texas has had limited success in their demonstration implementation in this area.

## **B. Core Values**

1. Long term care consumers in Michigan deserve access to the proactive care management services and improved outcomes currently provided to acute care consumers via Health Maintenance Organizations.
2. It is in the vital interest of Long Term Care consumers that the financial viability of long term care, in terms of the ability of consumers and taxpayers to continue to finance the system, be protected through the efficiencies of managed care.
3. The prevention or delay of progressive debilitation is of primary importance to long term care consumers, and this objective is promoted through active care management and subsequent provision of required services at the earliest possible juncture.
4. The integration of Medicaid and Medicare revenues create better service delivery for consumers and positive financial incentives for providers.

## **C. Unique Features**

1. This model attempts to transfer managed care technologies developed primarily in primary care settings to long term care.
2. Medicare and Medicaid funding streams are effectively integrated, without waiver, in the event the Long Term Care HMO is also a Medicare Managed Care or Medicare+Choice provider.

## **D. Incentives**

1. Consumer Incentives
  - Consumers prefer to have a say in their care. Service delivery under a person-centered, self-directed plan of care worked out with the assistance of a care manager is a strong incentive to participate. This approach reduces the burden on the consumer to find and arrange for services as under a fee for service model.
  - Enrollees may have access to value added services such as wellness and alternative and complementary medicine.
2. Provider incentives
  - Network providers will have a stable flow of beneficiaries and single point of contact.
  - Providers will have increased flexibility in services and settings of care.
  - Implementation of familiar managed care techniques will provide opportunity to provide care with improved cost-effectiveness while simultaneously promoting

quality.

- Opportunity to participate in a coordinated, comprehensive care plan focused on quality improvement, and increased patient satisfaction.

## **II. Model Locations**

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### **A. Site criteria**

1. Each site will have more than one long term care HMO in the area. The territory covered in the initial projects must encompass both urban and rural care settings. The area covered will be one or more counties.
2. Each area served by the long term care model should encompass a minimum of 2000 Medicaid long term care eligibles to achieve 500+ enrollees.

### **B. Number of sites**

1. At least two sites are desirable with the final number determined by the number and quality of the applications.

## **III. Model Provider Selection**

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### **A. Selection criteria**

1. These criteria are intended to reflect which organizations have a good fit with Michigan's vision for a new long term care system and experience with provision of quality long term care services in a capitated environment.
2. The ideal applicant will also be a participant in Medicare managed care or Medicare+Choice or will seek to become one.
3. In order to fulfill each of the following qualifications, strategic alliances may need to be formed between multiple organizations and/or applicants.
4. Specific criteria of selection include:
  - Established track record implementing managed care techniques
  - Established infrastructure for monitoring utilization and quality
  - Well defined plan for transferring managed care technologies to the long term care environment
  - Familiarity with Medicaid and Medicare managed care billing practices and

regulations

- Evidence of ability to form provider network capable of providing the full range of long term care services for each target group
- Administrative and information systems infrastructure to support managed care

## **B. Selection process**

1. Administrative selection based on demonstrated ability to meet established criteria and perform required functions.

# **IV. Participant Eligibility**

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## **A. Target Population**

1. The target population includes the following groups:
  - Adults with disabilities, including younger adults with long term disabling conditions
  - Frail elderly
  - Individuals with dementia/Alzheimer's
  - Individuals in need of end of life care
  - Involved families and caretakers

## **B. Specific eligibility criteria**

- Financial: Medicaid eligible or Medicaid/Medicare dual eligible, as currently defined by the Medicaid and Medicare programs, or:
- Financial: Non-Medicaid eligible Medicare beneficiaries may buy in to coverage of Medicaid services as a form of long term care insurance.
- Medical: In need of nursing home level of care.

## **C. Demographic profiles**

- The HMO will serve adults with disabilities aged 18 and older, and the elderly who have a medical necessity for long term care services. Beneficiaries will typically be financially eligible for Medicaid, although Medicare beneficiaries who are not financially eligible for Medicaid may buy in.

#### **D. Voluntary vs. mandatory**

1. Medicaid services: New Medicaid enrollees in the demonstration project's service area will receive LTC Medicaid services through the HMO. Participation will be voluntary for existing Medicaid long term care recipients.
2. Medicare services: Enrollees will be encouraged to select services through the HMO (where a Medicare+Choice or Medicare Managed Care plan is available). In order to overcome disincentives to doing so (including possible need to change provider and perceived disadvantages of managed care among the target population), incentives will need to be considered which might include:
  - Value added services (alternative and complementary therapies, improved pharmacy benefit, etc.)
  - Financial incentives (such as selective payment of Medicare cost sharing for managed care participants only)

#### **E. Geographic requirements**

1. Participants must reside within the HMO's defined service area.

### **V. Revenue Sources**

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Any third party insurance carried by the beneficiary.

Medicaid capitation payments to long term care HMO, covering long term care services and Medicaid covered medical services.

Medicare fee-for-service payments or, preferably, capitation payments to HMO (this would require that the HMO be a Medicare risk contractor), covering acute/primary care for Medicare eligibles. The capitated rate paid by the Health Care Financing Administration for Medicare beneficiaries as in any Medicare Risk Contract arrangement with an HMO would continue to be paid. The Medicare capitation covers primary and acute care services such as doctor's visits and hospitalizations. Medicare does not cover pharmacy.

If a dually eligible person did not elect the Medicare HMO, they would continue to obtain Medicare services as they had with assistance from the HMO. A separate capitated rate would be paid by the State Medicaid program to cover the long term care services, pharmacy, and other services provided to all Medicaid beneficiaries as well as to provide a strong care management service and to provide for necessary administration of the program.

## **VI. Benefit Design**

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Benefits will include the full range of existing Medicaid benefits available in the primary, acute, and long term care settings. The long term care benefits will be expanded to include support for people who live in any community based residential setting including licensed AFC and Home for the Aged settings. The full range of Medicaid benefits is described in the Appendix.

For enrollees with dual eligibility, when beneficiaries select the HMO for Medicare, the HMO would provide all health and medical services. Medicare benefits may be supplemented by the HMO to encourage Medicare participation.

For those dual eligibles not electing to receive Medicare medical services under the HMO, the HMO would provide Medicaid services and coordinate the Medicare services.

The HMO will be allowed, but not required, to pay for room and board costs in non-nursing home settings if they believe that would be cost effective in any specific situation.

Through the competitive selection process the Department of Community Health will encourage value added services focused on wellness and prevention, alternative and complementary medicine and information services. The LTC HMO will be encouraged to develop services of value to the individuals included in long term care.

## **VII. Administrative/Management Requirements**

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### **A. Size (covered lives and/or regional boundaries)**

1. The HMO should clearly document the number of covered lives it has determined will be necessary for its financial viability, and how it has determined that a market of sufficient size to provide this number of covered lives exists in the proposed service area.
2. The territory served must be a single county or group of contiguous counties with a minimum of 2000 Medicaid long term care eligibles.
3. The demonstration area will include a major metropolitan area and adjoining rural areas.

### **B. Fiduciary/corporate structure requirements**

1. The HMO must be licensed and comply with all fiduciary and solvency requirements prescribed by state and federal government.

### **C. Accreditation**

1. Accreditation by a nationally recognized accrediting body is required.

**D. Profit, non-profit status**

1. Both not-for-profit and for-profit plans will be accepted.

**E. MIS requirements**

1. The HMO will be required to integrate with the MI Choice Information System (MICIS), as well as complying with the reporting requirements of MDS, HEDIS, OASIS, etc.
2. The HMO must also demonstrate staff capacity, availability of hardware/software necessary to integrate with MICIS and related components.

**F. Financial systems, claims processing**

1. The HMO must be able to track access, services delivered, and cost.
2. Administrative cost must be tracked and reported as a discrete cost category.
3. Profit or margin must be explicitly identifiable in the cost reporting system.
4. Provider claims shall be paid in a timely fashion.

**G. Access, utilization management system/protocols**

1. Access to the model will be through the MI Choice Access system.
2. The HMO is expected to use care management techniques incorporating assessment, monitoring, targeted care management for high cost or high needs cases and use modern information technology. Care management should be linked into the MI Choice Access process and also be linked into the quality assessment and assurance processes of the HMO.
3. Practice guidelines that model plans will be required to follow are under development.

**H. Organized community delivery system requirements, including collaborative agreements**

1. The HMO will need to establish sufficient collaborative agreements and contractual arrangements to assure a responsive network of providers to meet the care needs of all beneficiaries.

2. Collaborative agreements between various entities/applicants may promote the smooth application/transfer of managed care technology to long term care.

**I. Community benefit considerations**

1. The HMO shall seek to establish services that are available to the community as a whole, as well as to enrolled participants, including wellness programs for seniors and adults with disabilities, preventive services, etc.
2. Coordinating community resources may streamline access even for those recipients not enrolled in the HMO.
3. Profit or margin can be reinvested in the community in the form of additional free or reduced cost service.

**J. Acute vs. community based services management relationship**

1. Acute and community based providers will be incorporated into the HMO, and as such these services will be fully integrated.
2. Acute care and primary will be managed by the same corporate entity for those dual-eligible beneficiaries selecting the HMO for their Medicare benefits. Otherwise, the care manager will coordinate the enrollee's medically necessary acute care and routine preventive services which will be billed to Medicare under fee-for-service. The care manager will be expected to coordinate the long term care components with the acute/primary care provider(s).

**K. Consumer and family inclusion in service system design, implementation and monitoring**

1. Consumers will be involved in the development of outcome goals and measures and grievance procedures.
2. The plan of care shall be developed using a person centered approach.
3. The health plan must have a voluntary option available to consumers for them to self-direct the long term care portions of their care.

**L. Relationship, role responsibilities relative to DCH**

1. The relationship between DCH and the HMO will be contractual in nature. The HMO will be required to provide services and supports in accordance with contractual requirements.



2. DCH is responsible for quality oversight and fiscal and contractual monitoring of the HMO.

## **VIII. Financing Mechanisms**

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### **A. Rate determination method**

1. The State will conduct an actuarially sound analysis of fee-for-service costs in the defined service area and develop associated capitation projections.
2. The cost and capitation analysis will incorporate case mix and other adjustments such as Resource Utilization Group Score (RUGS), age, gender, and geography in the computation of rate cells.
3. The actual rate will be established through a competitive bidding process.

### **B. Payment method**

1. The Long Term Care HMO will be paid a fixed per member per month case mix adjusted rate for all persons who are Medicaid eligible and enrolled in the plan.

### **C. Risk bearing strategies**

1. The HMO will bear full financial risk for all Medicaid services.
2. Stop loss arrangements may be implemented in the initial years to risk share with the State, as the capitation system is refined. Risk sharing strategies based on corridors may be used in the first year of operation.

### **D. Cost containment strategies**

1. Active care management will promote timely delivery of community and preventative services designed to maintain wellness and prevent more costly acute care services.
2. Integration of Medicaid and Medicare capitations removes the incentive for cost and responsibility shifting and creates incentives for health maintenance.
3. Identifying a single entity responsible for coordinating services across both systems will result in fewer chronic health episodes and a corresponding decrease in the growth of expenditures for hospitalizations, pharmaceuticals and related health care costs.

## **IX. Customer Services**

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### **A. Beneficiary rights**

1. The HMO shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions and the right to a second opinion.
2. The consumer or authorized representative shall sign and date a statement indicating that they have received an explanation of consumer rights and responsibilities in writing, that the rights have been explained to them, and that they clearly understand.
3. These activities shall be conducted as part of the initial assessment process.

### **B. Beneficiary responsibilities**

1. The beneficiary is responsible to cooperate with the efforts of the care manager to coordinate preventative, acute/primary and long term care services.

### **C. Grievances and Appeals**

1. Consumers have the right to contest decisions affecting eligibility and services. Information shall be provided that clearly explains the grievance procedures established to address the beneficiary's right to appeal the decisions made by the provider.
2. Additionally, Medicaid clients have the right to a Medicaid Fair Hearing before an Administrative Law judge when they have received an adverse decision from a Medicaid provider.
3. The HMO organization, and its contractor shall follow all applicable rules, regulations, federal laws, state law and policies related to the programs established under this proposal.

### **D. Customer interests (handbook, education and training opportunities, information, etc.)**

1. The HMO shall develop and maintain consumer education materials designed to provide clear, concise, culturally sensitive and accurate information. Educational materials include but are not limited to a consumer handbook, bulletins or newsletters.
2. At a minimum, the consumer handbook shall detail:

- Consumer rights and responsibilities
- Plan benefits and limitations
- How to access providers and caregivers
- The role of the care manager and how to access and work with the care manager to develop a care plan and receive services
- Appeals processes
- Accessing emergency care

## **X. Service Planning and Care Management**

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### **A. Coordination with MI Choice Access**

1. Individuals shall be determined medically eligible by an authorized MI Choice Access organization prior to enrollment in the HMO.
2. Information collected during the eligibility determination process shall be provided electronically to the HMO to be used as the foundation upon which further assessment and care planning activities are conducted.

### **B. Access to plan process, services**

1. Following enrollment, the HMO shall assign a primary care manager who has responsibility for coordinating access to services within the plan. All activities shall be conducted within established timeframes to ensure timely access.
2. While no services outside the care plan (except emergency services) will be covered, the participant shall have timely access to re-evaluation of service needs on demand.
3. If the customer opts for self-directed services, the care manager will educate the customer on self-directed care and install tools and accounts necessary to support self-directed care. The care manager will coach and monitor the self-directed care for a three month period or as long as necessary to empower the consumer. The use of information technology will allow automated monitoring permitting timely intervention in the event of fraud or misunderstanding.
4. The contract will specify a minimum performance requirement for contact by the HMO after enrollment by the MI Choice Access agent.

### **C. Person centered planning process, care plan development**

1. All activities shall be conducted in the context of the person-centered plan. The development of the person-centered plan begins at enrollment. The primary care manager shall conduct an initial assessment with active participation of the consumer and others.
2. Based on assessment findings and expressed desires, the care manager and consumer develop a single plan of care that coordinates all aspects of service delivery across all care environments.
3. Consumers approve of the care plan prior to service implementation. Care managers or the consumer arrange services from the consumer's provider of choice. (Consumers must have a choice of providers within the provider panel to the maximum extent possible.)
4. When the consumer selects the voluntary option for self-directed care, care managers monitor and assist the consumer in their care choices. Opportunity for self-determination include:
  - Development of care plan, which must be approved by the participant
  - Choice of providers from the provider network for many services
  - The participant may “hire and fire” home and community based service providers

#### **D. Care management**

1. The assigned primary care manager shall provide care management, follow-up and monitoring on an ongoing basis according to established protocols.
2. The care manager will maintain contact with the participant, conducting in-home reassessments a minimum of every 90 days, or upon significant change or the recipient's request, to ensure the participant's health and safety in the least restrictive, most cost efficient setting.
3. The HMO shall have established protocols for 24 hour crisis resolution (e.g. if a family care giver is incapacitated due to illness or injury, the beneficiary may require immediate re-evaluation and subsequent modification of care plan to assure continuity of required services).
4. Individuals and family members are encouraged to assume as many of these responsibilities for themselves as possible and desired. A variety of care management/supports coordination models are available to meet the varying needs and preferences of individuals.

#### **E. Care plan outcomes evaluation, revisions**

1. Through the person-centered plan, goals and desired outcomes are established by the participant and care manager at case onset.
2. Periodic, required reassessment and reevaluation of the care plan allows for adjustments and revisions as necessary to address identified needs.

**F. Responsiveness to community, community inclusion**

1. HMOs are required by law to have consumer representatives on their governing Boards. These individuals will be substantively involved in the establishment of policies and the assessment of cumulative outcomes.
2. HMOs will be required to have agreements with the Area Agency on Aging, the CMH Service programs, and the Substance Abuse Coordinating agencies that specify coordination arrangements between the respective organizations.
3. It is expected that as the HMOs create its networks for delivering care it will, of necessity involve existing community resources. It is DCH's intent to create a strong link between aging/disability services and the long term care HMO without creating overlaps in spheres of responsibility.
4. The HMO will provide opportunity for the inclusion of existing community long term care service providers in the benefit package of the plan.

## **XI. Provider Network**

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**A. Scope and capacity of provider network**

1. The HMO shall have the capacity to provide all plan benefits on a direct basis or through affiliated providers.
2. The HMO shall assemble the network, credential providers and establish subcontract agreements as necessary to ensure adequate capacity.
3. The HMO shall be responsible for paying providers in a timely fashion for authorized services at the negotiated rate.

**B. Provider credentialing and privileging**

1. The HMO shall ensure providers meet established standards and licensing/certification requirements prior to utilizing them in the provision of services.
2. The HMO will take reasonable efforts to ensure that provider credentialing remains current.

3. While providers shall not be dismissed from the network without due cause, the HMO shall take reasonable efforts to ensure that network providers provide safe and effective care for their beneficiaries.

## **XII. Quality Assurance**

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### **A. Quality improvement process**

1. The HMO shall have a written quality assessment and improvement plan, and an established quality improvement program
2. The plan will include, and the program shall address, at a minimum, the following elements:
  - Service utilization (see below)
  - Care giver satisfaction and turnover
  - Participant satisfaction
  - Participant outcomes, as derived from periodic assessment data addressing the following:
    - ▶ Physiologic well being
    - ▶ Functional status
    - ▶ Cognitive ability
    - ▶ Social/behavioral function
    - ▶ Quality of life
    - ▶ Safety, efficacy, and timeliness of all services identified in the plans of care, whether clinical or non-clinical
    - ▶ Grievances and appeals
    - ▶ The HMO shall achieve minimum performance standards in each of these areas, to be negotiated between the State and HCFA, and documented in the HMO agreement.

### **B. Utilization, Performance/outcomes monitoring and evaluation**

1. The continuous quality improvement process must include documentation of the degree to which the program maximizes least-restrictive care and wellness.
2. This documentation shall include, but not be limited to:
  - Inpatient hospitalization rate
  - Institutional care utilization

- Emergency care utilization
- 3. The HMO shall establish one or more committees with both community and consumer representation to assess outcomes data and provide recommendations to the continuous quality improvement process.
- 4. The HMO shall report annually to the State on its progress in achieving the stated objectives of its quality assessment plan.
- 5. The HMO will be evaluated on its documented performance in terms of its stated objectives and the degree to which its performance exceeds past experience both within the program and the market at large.
- 6. The HMO will be expected to submit a revised quality assurance and improvement plan to the State annually, documenting how past shortcomings will be addressed and past successes built upon.

### **XIII. Long Term Care Reform Priorities**

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#### **A. Personal responsibility**

1. Individuals who are not financially eligible for Medicaid-funded benefits will be encouraged to participate in the plan on a private pay basis.
2. Provision of care management and supports coordination will assist individuals in using resources in a manner which allows them to support their long term care needs for a longer period of time, delaying their entry to the public system, and thereby reducing the overall expenditure of public funds on their behalf. In addition, utilization of care management services will delay or prevent morbidity, improving the beneficiary's quality of life.
3. Any third party insurance held by the beneficiary would be the payer of first resort.

#### **B. Housing**

1. Use of creative living environments to ensure the health and safety of plan participants will be encouraged.
2. Provision of services in assisted living and other supported living environments is expected to result in decreased health care expenditures for the target population.
3. Further, provision of services in the least restrictive, most cost effective environment will promote the simultaneous goals of cost containment and consumer satisfaction.

**C. Best practice guidelines**

1. Appropriate elements of practice guidelines established through development and implementation of the HCBW program will be incorporated into the contractual expectations of the plan.
2. Practice guidelines will be provided to each plan as a basis upon which to develop local practices.

**D. Self Determination and self-directed care**

1. For individuals who are capable of and willing to manage aspects of their own care it is expected that a consumer-directed purchasing option be available for the long term care components of their care.

## **XIV. Model Evaluation Considerations (see Evaluation Section)**

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**A. Outcomes achieved:**

1. Access
2. Quality
3. Cost

**B. Model implementation integrity:**

**C. Evaluation process:**

## **XV. Implementation Considerations**

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There has not been any experience with managed care in the long term care environment in Michigan. Some effort will be required to adapt existing managed care techniques and technologies for use in long term care and to bring in expertise to implement.

There are currently few Medicare managed care organizations in Michigan. The Department will need to dialogue with applicants to encourage their entry into Medicare managed care.

Michigan will need to obtain approval of federal Medicaid waivers to test the HMO model. However, one strength of the HMO model is that it can achieve a virtual integration of Medicare and Medicaid without the need for a Section 222 waiver.



# Regional Provider Organization

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## I. Introduction to the model

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### A. Overview

The Regional Provider Organization (RPO) is a partnership between multiple provider organizations to form a single, integrated service delivery system. It includes the full range of acute care and long term care benefits. It applies managed care principles of risk and capitation to a provider-driven alliance. The model utilizes a community-up design strategy, building an integrated service delivery system around the target population through the provider structure that exists within the defined service area. It allows the flexibility necessary to accommodate changing community needs, recognizing that one size does not fit all.

Each RPO will be distinct in its organization, adjusting the partnership as necessary to meet the changing needs of its customers. Participating organizations will likely include an area agency on aging, skilled and basic-care nursing facilities, primary care physicians, hospital systems, local health departments, home care agencies, community mental health services programs, assisted living residences, and other community organizations as deemed appropriate. Its development is fluid. At a minimum its membership must include providers that serve each of the target groups.

The model is community based, built upon resources that are available within existing systems. However, capacity building for some services and inclusion of partners with a broader base than a given community may be necessary in order to assure access to the full range of acute/primary care and community benefits, and to coordinate care and manage resources across these environments.

It is anticipated that the RPO will maximize the inclusion of people with disabilities and the elderly in all aspects of community living. Because this model is community based, it is intended to be particularly consumer driven and community supported in its design, implementation and ongoing quality improvement. Therefore, an expected outcome is that people enrolled with this model will have extensive opportunities to be woven into the total fabric of their community—including its social, recreational, spiritual, work and other contributory areas of life, in addition to health care services and supports.

It is essential for this model that it be both community supported and community based. It is expected that the RPO will be viewed by the community as an extension of itself, in many ways. Therefore, the RPO will give active consideration to its contributory role in the quality of life of the community, as well as that of its members. The community support that is given in return offers the potential to explore and expand new ways to blend public and private resource partnerships. This could occur at the system level in

terms of who the partners are in the RPO or with whom the partnership has contracts and coordinating agreements. For individuals considering enrolling in a MI Choice plan, the potential exists for people to enroll on a private pay basis or through public subsidy, as a mechanism for blending private and public resources at the consumer level. This would allow individuals access to supports and assistance with resource management earlier in the aging or disability process, extending both health and private resources.

Because the model is community based, it provides maximum opportunity for a plan to be constructed in a way that reflects and is sensitive to local cultural, economic and demographic profiles. It offers the opportunity for providers who have historically served these individuals and their families with commitment and understanding to help shape the new environment through responsible system administration and management, under a capitated, full risk model. This will require new ways of thinking and doing business for these entities, but it offers a leadership role for those willing and capable of aligning themselves differently under this model.

## **B. Core Values**

1. Local provider organizations know and understand the needs of local consumers and can organize an integrated service delivery system to meet those needs.
2. Local providers are known and trusted by local consumers. Local providers are responsive to local oversight and accountability.
3. The full range of services available in the community should have the tools and incentives necessary to coordinate their efforts to ensure that appropriate services are delivered efficiently and in the least disruptive manner possible.

## **C. Unique Features**

1. The RPO mirrors the federally defined Provider Service Organization's fundamental design strength: cost and quality are controlled by the same party—the providers—rather than being controlled by separated parties which are then necessarily in some degree of conflict with each other (as in a traditional HMO).
2. While the potential exists for this to create a moral hazard, committed providers within the RPO will be incentivized by their professional commitment to the patient to provide quality care while they are simultaneously incentivized by their financial stake in the organization to avoid waste.
3. In light of this, it will be important for the integrity of the system (as well as for compliance with federal law) to avoid financial arrangements that link individual provider resource utilization to remuneration. Instead, any financial incentives should be linked to the performance of the organization as a whole.

4. However, financial structures that incentivize individual provider's quality of care remain desirable.
5. Being community based, this system will minimize disruption in current service delivery (i.e. individuals can keep their existing providers to the extent they participate in the provider organization.)
6. Unification of the full range of service providers under one organization will promote communication, coordination of service delivery, preservation of wellness, and cost effectiveness.
7. This model can evolve from current primary long term care providers---waiver agents and nursing facilities.
8. Has the potential to leverage informal community resources including volunteer programs.

#### **D. Incentives**

1. Consumer Incentives
  - Allows consumers to continue to use their community providers but in a streamlined, less fragmented manner.
  - Service delivery under a person-centered, self-directed plan of care developed with the assistance of care manager where desired, will promote wellness and prevent debilitation.
2. Provider Incentives
  - Provides opportunity for improved cost-effectiveness through coordination of existing community resources and funding streams.
  - Provides opportunity to improve patient satisfaction through increased quality and better outcomes.
  - Assures opportunity to be a part of the provider panel for Medicaid long term care.

## **II. Model Locations**

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#### **A. Site criteria**

1. Ideally, the model will be tested in a variety of settings, both urban and rural, and within single and multiple county service areas.

2. Each site should encompass a minimum of 2000 Medicaid long term care eligibles to achieve 500+ enrollees.

#### **B. Number of sites**

1. A minimum of three is desired, with the final determination dependent upon the number and scope of applications received.

### **III. Model Provider Selection**

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#### **A. Selection criteria**

1. Desired characteristics of an RPO include experience serving the target population, demonstrated ability to manage benefits, proficiency in consumer choice models, sufficient administrative infrastructure and operational capacity to efficiently manage the system, certification of risk bearing capabilities, independent price calculations, and a willingness to fulfill all conditions of participation. Specifically:
2. Partnership must include agencies/organizations with demonstrated individual or collective experience in the provision of acute/primary health care services, care management/supports coordination, and long term care services and supports to the target population
3. Member organizations must represent all of the target populations. Member organizations may be readily identified as doing so by the target populations.
4. Member organizations must demonstrate the capacity to organize and build effective partnerships within the community.
5. Member organizations must demonstrate prior experience in working collaboratively with each other and the community.
6. Partnership must have ability to receive and manage required revenue sources.
7. Partnership must be organized as a legal entity capable of bearing full risk within 3 years (have or develop ability to serve as PSO or AFDS or HMO) meeting solvency requirements (to be established)

#### **B. Selection process**

1. Administrative selection based on demonstrated ability to meet established criteria and perform required functions.

## **IV. Participant Eligibility**

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### **A. Target Population**

1. Adults with disabilities, including younger adults with long term disabling conditions
2. Frail elderly
3. Individuals with dementia/Alzheimer's
4. Individuals in need of end of life care
5. Involved families and caretakers

### **B. Specific Eligibility Criteria**

1. Financial: Medicaid eligible or Medicaid/Medicare dual eligible, as currently defined by the Medicaid and Medicare programs, or:
2. Non-Medicaid eligible beneficiaries may buy-in to coverage of Medicaid services as a form of long term care insurance, or:
3. The RPO may leverage other revenue sources that will allow it to serve or subsidize care for people not financially eligible for Medicaid. The RPO may use re-directed Medicaid savings for this purpose as well.
4. Medical: For Medicaid eligibles, in need of nursing home level of care.
5. Medical: For non-Medicaid eligibles, medical eligibility criteria will be established either by the funding source or the RPO.

### **C. Demographic Profiles**

1. The RPO will serve adults with disabilities aged 18 and older, and the elderly who have a medical necessity for long term care services.

### **D. Voluntary vs. Mandatory**

1. Participation will be voluntary for existing Medicaid LTC recipients.
2. Participation will be mandatory for new Medicaid long term care enrollees.
3. Coordination of Medicare benefits will be voluntary until such time as the federal government approves a waiver or the RPO becomes a medicare risk contractor.

4. Private pay individuals will participate on a voluntary basis.
5. Other revenue sources managed by the RPO may require mandatory participation.

#### **E. Geographic requirements**

1. Participants must reside within the RPO's defined geographical service area.

### **V. Revenue Sources**

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Revenue sources will include Medicaid on a capitated basis, Older Americans Act and other aging services funding, local funding, private insurance, and private funds.

Medicare will be included either at the point the RPO achieves Medicare risk contractor status or when a federal waiver is approved.

The nature and scope of agencies included in the partnership could leverage additional local revenues.

### **VI. Benefit Design**

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Benefits will include the full range of existing Medicaid benefits available in the primary, acute, and long term care settings. The long term care benefits will be expanded to include support for people who live in any community based residential setting including licensed AFC and Home for the Aged settings. Medicaid benefits are described in the Appendix.

RPO coordinates Medicare benefit for enrollees with dual eligibility who do not enroll with the RPO for their Medicare services.

State and federal aging, behavioral health benefits and other publicly-funded services and supports are coordinated and/or integrated to the extent that the respective fund management entities are included in the partnership.

The RPO will be allowed, but not required, to pay for room and board costs in non-nursing home settings if they determine doing so would be cost effective in any specific situation.

Through the competitive selection process the Department of Community Health will encourage value added services focused on wellness and prevention alternative and complimentary medical services. The RPO will be encouraged to develop services of value to the individuals included in long term care.

## **VII. Administrative/Management Requirements**

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### **A. Size (covered lives and/or regional boundaries)**

1. The RPO should clearly document the number of covered lives it has determined will be necessary for its financial viability, and how it has determined that a market of sufficient size to provide this number of covered lives exists in the proposed service area.
2. The territory served must be a single county or group of contiguous counties with a minimum of 2000 Medicaid long term care eligibles.

### **B. Fiduciary/corporate structure requirements**

1. The RPO must demonstrate strong management structures that favor financial accountability and quality outcomes.
2. The RPO must have a plan for meeting State and Federal fiscal requirements for assuming risk.
3. Special favor will be shown to applicants presenting a plan for organizing at some point in the future as a Provider Service Organization as defined by HCFA.
4. The RPO shall have a governing board with representation from community members and consumers.
5. The RPO must be organized either as an Alternative Healthcare Financing and Delivery System, a Provider Service Organization, a SHMO or an HMO.
6. The RPO partnership must initially have representation from one or more providers serving each of the long term care target populations and subsequently from acute/primary providers as well.

### **C. Accreditation**

1. If not already accredited by a nationally recognized body, the RPO must submit an acceptable plan and timetable for achieving such accreditation.

### **D. Profit, non-profit status (including administrative cost/cap)**

1. The RPO will be a partnership that may include for-profit, not-for-profit and/or governmental entities. The fiscal fiduciary may be profit or non-profit.

### **E. MIS requirements**

1. The RPO will be required to integrate with the MI Choice Information System (MICIS), as well as complying with the reporting requirements of MDS, HEDIS, OASIS, etc.
2. The RPO must also demonstrate staff capacity, availability of hardware/software necessary to integrate with MICIS and related components.

**F. Financial systems, claims processing**

1. The RPO must be able to track access, services delivered, and cost.
2. Provider claims shall be paid in a timely fashion.
3. Administrative cost must be tracked and reported as a discrete cost category.
4. Profit or margin must be explicitly identifiable in the cost reporting system.

**G. Access, utilization management system/protocols**

1. Access to the model will be through the MI Choice Access system.
2. The RPO is expected to use care management techniques incorporating assessment, monitoring, targeted care management for high cost or high needs cases and use modern information technology. Care management should be linked into the MI Choice Access process and also be linked into the quality assessment and assurance processes of the RPO.
3. Practice guidelines that model plans will be required to follow are under development.

**H. Organized community delivery system requirements, including collaborative agreements**

1. The RPO shall maintain contractual relationships and/or collaborative agreements that encompass the full continuum of primary, acute and long term care services that may not be included as member partners.

**I. Community benefit considerations**

1. The RPO shall seek to establish services that are available to the community as a whole as well as enrolled participants, including wellness programs for seniors and adults with disabilities, preventive services, etc.
2. Coordinating community resources may streamline access even for those recipients not enrolled in the RPO.



3. Profit or margin can be reinvested in the community in the form of additional free or reduced cost service.

**J. Acute vs. community based services management relationship**

1. Medicaid acute and community-based providers will be incorporated into the RPO, and as such these services will be fully integrated.
2. Until such time as the RPO is an approved Medicare risk contractor, the RPO will coordinate acute and primary services for dually eligible enrollees.

**K. Consumer and family inclusion in service system design, implementation and monitoring**

1. Consumers will be involved in the development of outcome goals and measures, and in grievance procedures.
2. The plan of care shall be developed using a person centered approach.
3. The health plan must have a voluntary option available to consumers to self-direct the home-based long term care portions of their care.

**L. Relationship, role responsibilities relative to DCH**

1. The relationship between DCH and the RPO will be contractual in nature. The RPO will be required to provide services and supports in accordance with contractual requirements.
2. The Department of Community Health is responsible for quality oversight and fiscal and contractual monitoring of the RPO.

## **VIII. Financing Mechanisms**

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**A. Rate determination method**

1. The State will conduct an actuarially sound analysis of fee-for-service costs in the defined service area and develop associated capitation projections.
2. The cost and capitation analysis will incorporate case mix and other adjustments such as Resource Utilization Group score (RUGS) age, gender, and geography in the computation of rate cells.
3. The actual rate will be established through a competitive bidding process.

## **B. Payment method**

1. Initially services will be reimbursed on a fee-for-service basis. Expenditure targets will be established for the RPO to manage with-in. A fixed administrative fee for the RPO will be established through a competitive bidding process.
2. Movement to capitation can be on a phased basis, starting with long term care and moving to acute/primary if desired by the applicant.
3. Eventually (within no more than 5 years) payment for both acute/primary and long term care services will be made on a capitated, per member per month basis.

## **C. Risk bearing strategies**

1. Financial control is obtained initially through establishment of expenditure targets and risk sharing arrangements.
2. Through time, as the RPO grows into a full managed care entity, it assumes an increased amount of risk.
3. Within the RPO, risk is shared among partners in a manner that is defined by the partnership.

## **D. Cost containment strategies**

1. Active care management will promote timely delivery of community and preventative services designed to maintain wellness and prevent more costly acute care services.
2. Identifying a single entity responsible for coordinating services across both systems will result in fewer chronic health episodes and a corresponding decrease in the growth of expenditures for hospitalizations, pharmaceuticals and related health care costs.

# **IX. Customer Services**

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## **A. Beneficiary rights**

1. The RPO shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions and the right to a second opinion.
2. The consumer or authorized representative shall sign and date a statement acknowledging that an explanation of consumer rights and responsibilities has

been provided in writing, that their rights and responsibilities have been explained to them, and that they clearly understand.

3. These activities shall be conducted as part of the initial assessment process.

## **B. Beneficiary responsibilities**

1. The beneficiary is responsible to cooperate with the efforts of the case manager to coordinate preventative, acute/primary and long term care services.

## **C. Grievances and Appeals**

1. Consumers have the right to contest decisions affecting eligibility and services. Information shall be provided that clearly explains the grievance procedures established to address the beneficiary's right to appeal the decisions made by the provider.
2. Additionally, Medicaid clients have the right to a Medicaid Fair Hearing before an Administrative Law judge when they have received an adverse decision from a Medicaid provider.
3. The RPO organization, and its contractor shall follow all applicable rules, regulations, federal laws, state law and policies related to the programs established under this proposal.

## **D. Customer interests (handbook, education and training opportunities, information, etc.)**

1. The RPO shall develop and maintain consumer education materials designed to provide clear, concise, culturally-sensitive and accurate information. Educational materials include but are not limited to a consumer handbook, bulletins or newsletters.
2. At a minimum, consumer handbook shall detail:
  - consumer rights and responsibilities
  - plan benefits and limitations
  - accessing providers and caregivers
  - appeals processes
  - accessing emergency care

## **X. Service Planning and Care Management**

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### **A. Coordination with MI Choice Access**

1. Individuals shall be determined medically eligible by an authorized MI Choice Access organization prior to enrollment in the RPO.
2. Information collected during the eligibility determination process shall be provided electronically to the RPO to be used as the foundation upon which further assessment and care planning activities are conducted.

### **B. Access to plan process, services**

1. Following enrollment, the RPO shall assign a primary care manager who has responsibility for coordinating access to services within the plan.
2. While no services outside the care plan (except emergency services) will be covered, the participant shall have timely access to re-evaluation of service needs on demand.
3. The contract will specify a minimum performance requirement for contact by the RPO after enrollment by the MI Choice Access organization.
4. If the customer opts for self-directed services, the care manager will educate the customer on self-directed care and install tools and accounts necessary to support self-directed care. The care manager will coach and monitor the self-directed care for a three month period or as long as necessary to empower the consumer. The use of information technology will allow automated monitoring permitting timely intervention in the event of fraud or misunderstanding.

### **C. Person centered planning process, care plan development**

1. All activities shall be conducted in the context of the person-centered plan. The development of the person-centered plan begins at enrollment. The primary care manager shall conduct an initial assessment with active participation of the consumer and others.
2. Based on assessment findings and expressed desires, the care manager and consumer develop a single plan of care that coordinates all aspects of service delivery across all care environments.
3. Consumers approve of the care plan prior to service implementation. Care managers arrange services from the consumer's provider of choice. (Consumers must have a choice of providers within the provider panel to the maximum extent possible.)

4. When the consumer selects the voluntary option for self-directed care, care managers monitor and assist the consumer in their care choices. Opportunity for self-determination include:
  - Development of care plan which must be approved by the participant
  - Choice of provider from provider network for many services
  - The participant may “hire and fire” home and care service providers

#### **D. Care management**

1. The assigned primary care manager shall provide care management, follow-up and monitoring on an ongoing basis according to established protocols.
2. The care manager will maintain contact with the participant, conducting in-home reassessments a minimum of every 90 days, or upon significant change or participant request, to ensure the participant’s health and safety in the least restrictive, most cost efficient setting.
3. The RPO shall have established protocols for 24 hour crisis resolution (e.g. if a family care giver is incapacitated due to illness or injury, the consumer may require immediate re-evaluation and subsequent modification of care plan to assure continuity of required services).
4. Individuals and family members are encouraged to assume as many of these responsibilities for themselves as possible and desired. A variety of care management/supports coordination models are available to meet the varying needs and preferences of individuals.

#### **E. Care plan outcomes evaluation, revisions**

1. Through the person-centered plan, goals and desired outcomes are established by the participant and care manager at case onset.
2. Periodic, required reassessment and reevaluation of the care plan allows for adjustments and revisions as necessary to address identified needs.

#### **F. Responsiveness to community, community inclusion**

1. Because the RPO has, in some respects, the community as both its “owner” and its beneficiary, it is involved in a dynamic, reciprocal relationship with the community.
2. The RPO partnership is developed in a manner that creates the flexibility necessary to address the ever-changing needs of community members. Community and private resources are utilized in partnership with public funds to

develop a service system based on the values and expressed needs of the community as a whole, as well as those of the individuals enrolled.

3. Providers, community stakeholders and consumers are all involved in service development and plan evaluation.
4. The community is understood to be “inside” and part of the RPO—and therefore its enrollees are intended to be able to move seamlessly across all aspects of community living. This represents one of the most unique and most exciting aspects of the RPO model.

## **XI. Provider Network**

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### **A. Scope and capacity of provider network**

1. The RPO shall have the capacity to provide plan benefits on a direct basis or through affiliated providers.
2. The RPO shall assemble the network, credential providers and establish subcontract agreements as necessary to ensure adequate capacity.
3. The RPO shall be responsible for paying providers in a timely fashion for authorized services at the negotiated rate.

### **B. Provider credentialing and privileging**

1. The RPO shall ensure providers meet established standards and licensing/certification requirements prior to utilizing them in the provision of services.
2. The RPO will take reasonable efforts to ensure that provider credentialing remains current.
3. While providers shall not be dismissed from the network without due cause, the RPO shall take reasonable efforts to ensure that network providers deliver safe and effective care for plan beneficiaries.

## **XII. Quality Assurance**

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### **A. Quality improvement process**

1. The RPO shall have a written quality assessment and improvement plan, and an established quality improvement program.

2. The plan will include, and the program shall address, at a minimum, the following elements:
  - Service utilization (see below)
  - Care giver satisfaction and turnover
  - Participant satisfaction
  - Participant outcomes, as derived from periodic assessment data addressing the following:
    - ▶ Physiologic well being
    - ▶ Functional status
    - ▶ Cognitive ability
    - ▶ Social/behavioral function
    - ▶ Quality of life
    - ▶ Safety, efficacy, and timeliness of all services identified in the plans of care, whether clinical or non-clinical.
    - ▶ Grievances and appeals
    - ▶ The RPO shall achieve minimum performance standards in each of these areas, to be negotiated between the State and HCFA, and documented in the RPO agreement.

**B. Utilization, Performance/outcomes monitoring and evaluation**

1. The continuous quality improvement process must include documentation of the degree to which the program maximizes least-restrictive care and wellness.
2. This documentation shall include, but not be limited to:
  - Inpatient hospitalization rate
  - Institutional care utilization
  - Emergency care utilization
3. The RPO shall establish one or more committees with both community and consumer representation to assess outcomes data and provide recommendations to the continuous quality improvement process.
4. The RPO shall report annually to the State on its progress in achieving the stated objectives of its quality assessment plan.
5. The RPO will be evaluated on its documented performance in terms of its stated objectives and the degree to which its performance exceeds past experience both within the program and the market at large.

6. The RPO will be expected to submit a revised quality assurance and improvement plan to the State annually, documenting how past shortcomings will be addressed and past successes built upon.

### **XIII. Long Term Care Reform Priorities**

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#### **A. Personal responsibility**

1. Individuals who are not financially eligible for Medicaid-funded benefits will be encouraged to participate in the plan on a private pay basis.
2. Provision of care management and supports coordination will assist individuals in using resources in a manner which allows them to support their long term care needs for a longer period of time, delaying their entry to the public system, and thereby reducing the overall expenditure of public funds on their behalf.
3. Any third party insurance held by the participant will be the primary payer.

#### **B. Housing**

1. Use of creative living environments to ensure the health and safety of plan participants will be encouraged.
2. Provision of services in licensed and unlicensed assisted living and other supported living environments is expected to result in decreased health care expenditures for the target population.
3. Further, provision of services in the least restrictive, most cost effective environment will help achieve the desired goal of cost containment.

#### **C. Best practice guidelines**

1. Appropriate elements and practice guidelines established through development and implementation of the home and community based waiver program will be incorporated into the contractual expectations of the plan.
2. Practice guidelines will be provided to each plan as a basis upon which to develop local practices.

#### **D. Self Determination and self-directed care**



1. For individuals who are capable of and willing to manage aspects of their own care it is expected that a consumer-directed purchasing option be available for the long term care components of their care.

#### **XIV. Model Evaluation Considerations (see Evaluation Section)**

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**A. Outcomes achieved:**

1. Access
2. Quality
3. Cost

**B. Model implementation integrity:**

**C. Evaluation process:**

#### **XV. Implementation Considerations**

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The organizational structure of the RPO has to be further defined. Community-based organizations that are designated as required partners are currently not organized to bear risk.

Organizations that will be partners are currently often competitors, with very different ideas on how the needs of the target population should be met.

It will be necessary to obtain approval of federal Medicaid waivers to test the RPO model. Future integration of the Medicare benefit will require a Section 222 waiver.



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# Virtual Organization

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## I. Introduction to the model

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### A. Overview

Over the past few years, virtual organizations have begun to rapidly emerge as a dynamic organizing model for business. Once just an idea, “e-business” is here today as a way to buy cars, to purchase clothes and to arrange services all from your home. The virtual organization is an e-business model characterized by electronic communication linking together components of a corporation, or partner corporations, to respond to market opportunities. A virtual organization does not need to own all parts of the business organization to meet a particular market demand. It can add parts through contract, agreement, and electronic linkages. Advantages of the model include great flexibility and partnerships and work arrangements that are not bound by geographic considerations. Application of ‘just in time’ inventory and the use of flexible contracting arrangements are other characteristics of virtual organizations. In the health care sector, virtual organizations are part of network creation and management. Increasingly health systems are ‘wired’ to link all providers and many health systems are exploring e-business concepts.

### B. Core Values

1. Long term care consumers in Michigan deserve to reap the benefits of rapidly developing information technologies.
2. Information technology should be made user friendly and accessible to long term care consumers.
3. Access, quality, and cost-effectiveness can and must be maximized through the application of information technology and virtual organization theory.
4. Virtual organizations provide opportunities to leverage personal responsibility.

### C. Unique Features

1. The virtual organization utilizes information technology and modern system design theory to revolutionize the delivery of long term care services.
2. Consumers will have unprecedented access to information and automated, streamlined service referral and delivery.

3. Providers will have unprecedented access to resource allocation and consumption data, which can maximize efficiency and allow rapid identification of needs and quality issues.
4. Assessments and services flow in real time.
5. Flexible and responsive to consumer needs.
6. Quality can be monitored and encouraged in real time

#### **D. Incentives**

1. Consumer Incentives
  - Centralized access to an unprecedented array of information that facilitates access and provider selection that is controlled by the consumer and family.
  - Ease of access to a vast array of information about long term care options, providers and their own care plan from their own home, the office of their care manager, and other settings.
  - Service delivery under a person-centered, self-directed plan of care developed with the assistance of care manager where desired.
2. Provider incentives
  - Centralized access to unprecedented array of information facilitating efficient service provision and resource utilization
  - Opportunity to administer a coordinated, comprehensive care plan facilitated through improved information access leading to cost savings, quality improvement, and increased patient satisfaction.

#### **E. A Virtual Organization Story**

The following story depicts an interaction with the imagined virtual organization from the consumer point of view and introduces concepts from the approach:

Rose is an 87 year-old widow with diabetes and deficiencies in three late onset Activities of Daily Living. She has managed to remain in her home and wants to stay there but needs some help. Her 71 year-old daughter Sarah, who has helped her, is sick and can't help out as much. Rose goes to the local senior center to learn about services available. There is a person there from the local information and assistance center with a computer. They talk about Rose's needs, strengths and desires, then complete an assessment process immediately. The assessment computer is linked to a set of long term care services through the organization responsible for service channeling. The person completing the assessment receives immediate feedback telling them what the assessment said about Rose's service needs and a case-mix indicator. Rose and the senior center worker review

and discuss the recommendations. Because of financial tests built into the assessment Rose would be routed electronically to the County Family Independence Agency to schedule a visit to apply for public assistance. At the same time routing logic would link Rose and the caseworker into a clearinghouse for the services that seem appropriate to Rose.

The clearinghouse would contain dynamic links so that Rose would be linked immediately to a home health provider with available capacity. The consumer could browse something like a web site that would contain cost information and maybe even an on-line tour of the provider and its services. After the electronic tour Rose decides to enroll in the VO and decides to manage her own care. She is assigned a care manager and given a monthly budget as part of the VO's voluntary self-determination option. She goes home and links in via her Web TV and immediately schedules the intake appointment, and verifies and forwards her assessment information. The system updates the clearinghouse by putting a hold on one home health opening that was previously available and at the same time notifying the FIA that services are available pending their eligibility determination for assistance. (If Rose's internet link is down, she just calls the clearinghouse and makes choices with her push button phone, or talks to a facilitator, if she needs personal contact.) The home health site receives the assessment and consumer preference information and sends a welcoming e-mail to Rose. The assessment and service package indicate that other services such as physical therapy services and home modification services are needed. Rose notifies the responsible organization that she is interested but needed to wait for the pending eligibility determination. Rose sends e-mail to her care manager that she needs help finalizing the home modification and arranging for physical therapy paid for by Medicare. With Rose's permission and an electronic key from her, the care manager pulls up Rose's information and forwards a notice to the physical therapy partner organization and to the building contractor to schedule services. Because Medicare covers therapy, the physical therapy provider immediately schedules the therapy assessment visit and updates the clearinghouse that one less assessment time period is available in the following week. The housing modification contractor electronically pencils in the work but waits for eligibility determination and direction from the organization managing the care. When the therapy provider completes the assessment, information on the service and billable events becomes available in real time to the coordinating agency and to the Department of Community Health for payment and program management. The care manager sends a note back to Rose telling her that the arrangements have been made. Appropriate amounts have been subtracted from Rose's monthly budget for services and holds put on funds for services scheduled for future periods.

The care manager also notes that Rose's daughter needs some respite to assist her in continuing to help her mother. She checks a box on the electronic form and the system automatically sends out a letter telling Sarah about the local respite program and the adult day care. It also points Sarah to a local web-site that provides information on caring for someone with diabetes and even has a chat room to discuss what's going on with caregivers like Sarah. The worker sets the computer to call Rose on the afternoon that Sarah is not there to remind her to take her insulin. From then on, every Thursday afternoon, Rose gets a call asking her if she took her insulin. Her voice response of "yes"

is stored in a database. If Rose says “no”, the computer calls Rose back in an hour. At this point if the response is not “yes”, the computer notifies Rose’s care manager, who gives her a call.

## **II. Model Locations**

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### **A. Site criteria**

1. Development of this model will depend on strategic partnerships between provider organizations and technology companies. At this time we anticipate that this model will require cooperative development that involves state, local and business organizations.
2. Size – The territory served must include a minimum of 2000 Medicaid long-term care recipients with an anticipated enrollment of 500+ people. However, one of the characteristics of the virtual organization is scalability and therefore, different enrollment targets may be suggested and justified in the application.
3. Location – The virtual organization uses technology to reach across geographic barriers. In terms of recipients, special favor will be shown to projects designed to serve both rural and urban recipients. High speed communication lines and technology availability are desirable features in a development site.

### **B. Number of sites**

1. The model will be initially tested in at least one area that includes both urban and rural settings. The location will be selected to leverage local provider interest and support for emerging technologies. However one of the characteristics of a virtual organization is its scalability. Depending on the proposal the system could initially be developed in a limited setting and expanded as part of the demonstration effort.
2. Added sites may be selected based on the applications received.

## **III. Model Provider Selection**

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### **A. Selection Criteria**

1. The Virtual Organization model requires a blending of technology and health service expertise. Because this is new approach, the selection criteria are intended more as guiding principles than as specifications for selection.

2. Desired characteristics of a virtual organization encompass skill and knowledge components: a management component focused on demonstrated ability to manage and deliver high quality long term care and medical benefits, and proven proficiency in consumer choice models; a technology component including experience in systems and technology integration and consumer-friendly use of web and telephony; and a service component including experience serving the target population across a full continuum of long term care and acute and primary care. Specifically:
  - Partnerships to include businesses, agencies, and organizations with demonstrated individual or collective experience in the provision of acute/primary health care services, care management/supports coordination, and the full continuum of long term care services and supports to the target population as well as proven experience delivering services through an ebusiness model.
  - Strong ties to community organizations.
  - The partners demonstrate successful implementation of user-friendly communication technology including communication, information sharing, electronic commerce, quality monitoring, and customer communication. Communication means will include telephone, computer-based, and in person contact.
  - The organization demonstrates proven ability to implement federal and state assessment requirements at points of service that insure the customer flexible entry to the organization and obtaining medical and long term care services.
  - The partnership must provide the full continuum of long term care, primary care, and acute care services in the service area.
  - The partnership must also provide information-based services that assist customers in managing their own long term care services and in assisting the State in managing service delivery and quality.
  - The service delivery system must include provisions for person centered care planning and for electronic self-directed care for home-based services. Participant counselors must be available to assist consumers in making care management decisions. Participant counselors must be available by electronic communication, telephone, and in person, if necessary.
  - Member organizations must demonstrate evidence of high quality performance in past work. Extensive references must be provided.
  - Partnership has ability to receive and manage required revenue sources.
  - Partnership is organized as a legal entity capable of bearing risk (have or develop ability to serve as HMO, PSO or AFDS) and can meet solvency requirements (to be established)

## **B. Selection process**

- Administrative selection based on demonstrated ability to meet established criteria and perform required functions.

## **IV. Participant Eligibility**

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### **A. Target Population**

1. Adults with disabilities, including younger adults with long term disabling conditions
2. Frail elderly
3. Individuals with dementia/Alzheimer's
4. Individuals in need of end of life care
5. Involved families and caretakers

### **B. Specific eligibility criteria**

1. Financial: Medicaid eligible or Medicaid/Medicare dual eligible, as currently defined by the Medicaid and Medicare programs, or:
2. Non-Medicaid eligible beneficiaries may buy-in to coverage of Medicaid services as a form of long term care insurance, or:
3. The VO may leverage other revenue sources that will allow it to serve or subsidize care for people not financially eligible for Medicaid. The VO may use re-directed Medicaid savings for this purpose as well.
4. Medical: For Medicaid eligibles, in need of nursing home level of care.
5. Medical: For non-Medicaid eligibles, medical eligibility criteria will either be established by the funding source or the VO.

### **C. Demographic profiles**

1. The virtual organization will serve adults with disabilities aged 18 and older, and the elderly who have a medical necessity for long term care services.

### **D. Voluntary vs. mandatory**

1. Participation will be voluntary for existing Medicaid LTC recipients.



2. Participation will be mandatory for new Medicaid long term care enrollees.
3. Coordination of Medicare benefits will be voluntary until such time as the federal government approves a waiver, or becomes a Medicare risk contractor.
4. Private pay individuals will participate on a voluntary basis.

#### **E. Geographic requirements**

1. Participants must reside within the defined service area of the virtual organization to receive services from the organization. Information services that are available through web-based tools must be available to the public as well as to enrollees.

### **V. Revenue Sources**

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Revenue sources will include a Medicaid per enrollee per month capitation, Older Americans Act and other aging services funding, local funding, private insurance, and private funds.

Medicare will be included either at the point the VO achieves Medicare risk contractor status or when a federal waiver is approved.

The nature and scope of agencies included in the partnership could leverage additional local revenues.

### **VI. Benefit Design**

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Benefits will include the full range of existing Medicaid benefits available in the primary, acute, and long term care settings. The long term care benefits will be expanded to include support for people who live in any community based residential setting including licensed AFC and Home for the Aged settings. Medicaid benefits are described in the Appendix.

The VO will coordinate Medicare benefit for enrollees with dual eligibility who do not enroll with the VO for their Medicare services by providing case management, monitoring and information services.

State and federal aging, behavioral health benefits and other publicly-funded services and supports are coordinated and/or integrated to the extent that the respective fund management entities are included in the partnership or through cooperation agreements.

Sophisticated information services will be provided to members and the public. Privacy of members will be protected.

The VO will be allowed, but not required, to pay for room and board costs in non-nursing home settings if they believe that would be cost effective in any specific situation.

Through the competitive selection process the Department of Community Health will encourage value added services focused on wellness and prevention, alternative and complimentary medicine and information. The VO will be encouraged to develop services of value to the individuals included in long term care.

#### **A. Assistive Technology in LTC**

1. Assistive technology has enormous potential to enhance both the effectiveness and efficiency of long term care. While it is relevant to any model of service management, its potential may be most fully realized in the Virtual Organization model.
2. In all models, long term care would be enhanced by assessment methodologies that facilitated consideration of assistive technology options (e.g. bathroom modifications vs. personal care for bathing, or electronic reminders vs. supervision for ADLs). A management entity would also need the capacity to do specific assessments (e.g. speech and language assessments for communication devices), and to provide consumers with services that promoted informed choice and addressed resistance to technology (e.g. a loan “library” of devices, or an AT center for testing different devices).
3. The Virtual Organization model would provide a setting for exploring more extensive technologies and emerging technologies. For example, a Virtual Organization might use the internet to inform consumers of assistive technology options, or offer self-assessment instruments to clarify need and interests. An individual might use environmental controls to increase personal independence and reduce the need for personal care. Or, rural consumers might use home computers for audio and video interaction with care managers, medical personnel and a support network.

## **VII. Administrative/Management Requirements**

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#### **A. Size (covered lives and/or regional boundaries)**

1. The VO should clearly document the number of covered lives it has determined will be necessary for its financial viability, and how it has determined that a market of sufficient size to provide this number of covered lives exists in the proposed service area.
2. The territory served must be a single county or group of contiguous counties with a minimum of 2000 Medicaid long term care eligibles.

## **B. Fiduciary/corporate structure requirements**

1. The virtual organization may be developed under fee-for-service. However, the intent is to have the virtual organization migrate to an at-risk entity. The virtual organization must eventually meet HMO or Alternative Healthcare Financing and Delivery System requirements.
2. The organization must demonstrate strong management structures that favor financial and quality accountability and consumer empowerment.
3. The VO shall have a governing board with representation from community members and consumers.

## **C. Accreditation**

1. If not already accredited by a nationally recognized body, the VO must submit an acceptable plan and timetable for achieving such accreditation, if such accreditation standards apply.

## **D. Profit, non-profit status**

1. The virtual organization could be profit or non-profit.

## **E. MIS requirements**

1. The virtual organization must have communication expertise as well as hardware and software to support the communication and e-business requirements of communicating with beneficiaries and delivering medical and long term care services. All hardware and software to support these efforts will be the responsibility of the VO.
2. The VO will be required to integrate with the MI Choice Information System (MICIS), as well as comply with the reporting requirements of MDS, HEDIS, OASIS, etc.
3. The VO must also demonstrate staff capacity, availability of hardware/software necessary to integrate with MICIS and related components.

## **F. Financial systems, claims processing**

1. If fee-for-service billing is used for the initial implementation period, the virtual organization will submit claims and/or encounter data in order to get paid. The VO must be able to track access, services delivered, and cost. As the VO assumes risk it will report encounters and/or shadow claims to allow cost analysis and modeling.

2. Administrative cost must be tracked and reported as a discrete cost category.
3. Profit or margin must be explicitly identifiable in the cost reporting system.
4. Provider claims shall be paid in a timely fashion. By design, the VO should incorporate electronic fund transfer and risk sharing to partners and providers.
5. The Department of Community Health is responsible for quality oversight and fiscal and contractual monitoring of the VO.

**G. Access, utilization management system/protocols**

1. Access to the model will be through the MI Choice Access system.
2. The VO is expected to use modern electronic communication and care management techniques incorporating assessment, monitoring, targeted care management for high cost or high needs cases and use modern information technology. Care management should be linked to the consumer and into the quality assessment and assurance processes of the VO.
3. Practice guidelines that model plans will be required to follow are under development.

**H. Organized community delivery system requirements, including collaborative agreements**

1. The virtual organization will link community businesses, organizations, and service providers through service agreements and information technology links as well as through formal contracts to promote the flexibility and demand/supply responsiveness at the heart of the virtual organization's efficiency.
2. The VO shall assure the availability of the full continuum of Medicaid supported medical and long term care services for its enrollees.
3. The virtual organization will have established protocols for auditing and ensuring timely service provision on the part of community providers in response to service requests generated by the system.

**I. Community benefit considerations**

1. The virtual organization will create an information network that could potentially provide resource and performance information to individuals the broader community in addition to enrollees.
2. Coordinating community resources may streamline access even for those recipients not enrolled in the VO.

3. The virtual organization will provide a model for other service organizations.

**J. Acute vs. community based services management relationship**

1. Medicaid acute and long term care providers will be incorporated into the VO, and these services will be fully integrated for the target population.
2. Until such time as the VO is an approved Medicare risk contractor, the VO will coordinate acute/primary services for dually eligible enrollees.
3. Using information technology, the virtual organization will provide seamless, automated referral and resource allocation between the long term care and acute care settings, including transport, admission, discharge, and reintegration support.

**K. Consumer and family inclusion in service system design, implementation and monitoring**

1. Consumers will be included in the development of outcome goals and measures, and in grievance procedures.
2. The plan of care shall be developed and updated in real time communication with the consumer using person centered planning techniques.
3. The health plan must have a voluntary option available to consumers to self-direct at least the home-based long term care portions of their care.

**L. Relationship, role responsibilities relative to DCH**

1. During development the VO and the State will be engaged in a joint venture. Once operational, the relationship between DCH and the virtual organization will be contractual in nature. The VO will be required to provide services and supports in accordance with contractual requirements.
2. DCH is responsible for the quality, oversight, fiscal and contractual monitoring of the VO.

## **VIII. Financing Mechanisms**

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**A. Rate determination method**

1. The State will conduct an actuarially sound analysis of fee-for-service costs in the defined service area and develop associated capitation projections.

2. The cost and capitation analysis will incorporate case mix and other adjustments including Resource Utilization Group score (RUGS) age, gender, and geography in the computation of rate cells.
3. The actual rate will be established through a competitive bidding process.

#### **B. Payment method**

1. Because the virtual organization needs to be developed, initial payment may be through the fee for service system with expenditure targets. Expenditures will be tracked electronically in real time. The virtual organization and the State will share risk beyond fee-for-service projections.
2. Eventually, the plan will receive a monthly capitation payment computed as described above for each member and be at full risk.

#### **C. Risk bearing strategies**

1. Financial control is obtained initially through establishment of expenditure targets and risk sharing arrangements.
2. Through time, as the VO grows into a full managed care entity, it will assume full risk.
3. Within the VO, risk may be shared among partners in a manner that is defined by the partnership and may be metered electronically.

#### **D. Cost containment strategies**

1. DCH expects that the full range of managed care cost efficiency opportunities will be used by the virtual organization. These include administrative management of the service delivery network, information and care management, preventive services, leveraging of marginal resources, especially private funds and insurance, and personal responsibility.
2. Through the use of information technology, public, personal and community resources can be optimized in ways that optimize service delivery and improve consumer control and satisfaction.
3. Improved access to services through consumer information and automated referral tools will promote health maintenance and potentially decrease acute care service utilization.

## **IX. Customer Services**

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### **A. Beneficiary rights**

1. The VO shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions and the right to a second opinion.
2. A record, paper or electronic, with appropriate written or digital signature shall be created which indicates receipt, time, and understanding of rights and responsibilities.
3. These activities shall be conducted as part of the initial assessment process.

### **B. Beneficiary responsibilities**

1. The participant, or authorized representative must provide all necessary information for participation and participate in care planning and delivery to the extent practicable.
2. The participant is responsible for cooperating with the care manager's efforts to connect the participant to needed services.
3. The participant shall make no effort to abuse, corrupt, or impair the information infrastructure to which the participant will be given access to promote their care. Furthermore, the participant will make no effort to gain unauthorized access to confidential information, nor shall the participant inappropriately give others access to PIN numbers or digital signatures the participant uses to access information and services through the system.

### **C. Grievances and Appeals**

1. Consumers have the right to contest decisions affecting eligibility and services. Information shall be provided that clearly explains the grievance procedures established to address the beneficiary's right to appeal the decisions made by the provider.
2. Additionally, Medicaid clients have the right to a Medicaid Fair Hearing before an Administrative Law judge when they have received an adverse decision from a Medicaid provider.
3. The VO organization, and its contractor shall follow all applicable rules, regulations, federal laws, state law and policies related to the programs established under this proposal

**D. Customer interests (handbook, education and training opportunities, information, etc.)**

1. The virtual organization shall develop and maintain consumer education materials designed to provide clear, concise, culturally sensitive and accurate information.
2. Educational materials include but are not limited to a consumer handbook, bulletins or newsletters. At a minimum, consumer handbook shall detail consumer rights and responsibilities, plan benefits and limitations, working with providers and caregivers, appeals processes, accessing emergency care.
3. The virtual organization shall use technology to provide customers with access to information electronically, but shall provide printed materials upon request.

**X. Service Planning and Care Management**

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**A. Coordination with MI Choice Access**

1. Individuals shall be determined medically eligible by an authorized MI Choice Access organization prior to enrollment in the VO. Information collected during the eligibility determination process shall be collected electronically and used as the foundation upon which further assessment and care planning activities are conducted.

**B. Access to plan process, services**

1. Following enrollment, the virtual organization shall assign a primary care manager who has responsibility for coordinating access to services within the plan.
2. All activities shall be conducted within established timeframes to ensure timely access.
3. If the customer opts for self-directed services, the care manger will educate the customer on self-directed care and install tools and accounts necessary to support self-directed care. The care manager will coach and monitor the self-directed care for a three-month period or as long as necessary to empower the consumer. The use of information technology will allow automated monitoring permitting timely intervention in the event of fraud or misunderstanding.

**C. Person centered planning process, care plan development**

1. All activities shall be conducted in the context of the person-centered plan. The development of the person-centered plan begins at enrollment. The primary care



manager shall conduct an initial assessment with active participation of the consumer and others.

2. Based on assessment findings and expressed desires, the care manager and consumer develop a single plan of care that coordinates all aspects of service delivery across all care environments.
3. Consumers approve of the care plan prior to service implementation. Care managers or the consumer arrange services from the consumer's provider of choice. (Consumers must have a choice of providers within the provider panel to the maximum extent possible.)
4. When the consumer selects the voluntary option for self-directed care, care managers monitor and assist the consumer in their care choices. Opportunity for self-determination include:
  - Development of care plan, which must be approved by the participant.
  - Choice of provider from provider network for many services.
  - The participant may “hire and fire” home care service providers.

#### **D. Care management**

1. The assigned primary care manager shall provide care management, follow-up and monitoring on an ongoing basis according to established protocols.
2. The care manager will maintain contact with the participant, conducting in-home reassessments a minimum of every 90 days, or upon significant changes, or upon the participant's request, to ensure the participant's health and safety in the least restrictive, most cost efficient setting.
3. The VO shall have established protocols for 24 hour crisis resolution (e.g. if a family care giver is incapacitated due to illness or injury, the beneficiary may require immediate re-evaluation and subsequent modification of care plan to assure continuity of required services).

#### **E. Care plan outcomes evaluation, revisions**

1. Through the person-centered plan, the Resident Assessment Instrument is completed, and the participant and care manager, at case onset, establish goals and desired outcomes. All of this is captured in a written care plan stored and available electronically to the customer, plan, and the State. Customer assessments and care plans are reviewed every 90 days and the care plan updated.

#### **F. Responsiveness to community, community inclusion**

1. The virtual organization shall establish linkages to community businesses and organizations.
2. The VO will be required to have agreements with the Area Agency on Aging, the CMH Service programs, and the Substance Abuse Coordinating agencies that specify coordination arrangements between the respective organizations.
3. It is expected that as the VO creates its network for delivering care it will, of necessity, call on existing community resources. It is DCH's intent to create a strong link between aging/disability services and the VO without creating overlaps in spheres of responsibility.

## **XI. Provider Network**

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### **A. Scope and capacity of provider network**

1. The prime contractor in the virtual organization shall have the responsibility and capacity to provide plan benefits on a direct basis or through affiliated providers.
2. The prime contractor shall assemble the network, credential providers and establish subcontract agreements as necessary to ensure adequate capacity or the full range of primary and acute care and long term care services.
3. The prime contractor shall be responsible for paying providers and subcontractors in a timely fashion for authorized services at the negotiated rate.
4. The prime contractor shall be responsible for linking providers and consumers through electronic information technologies.
5. Information technology will allow monitoring of the adequacy of the network to provide services in a timely fashion.

### **B. Provider credentialing and privileging**

1. The virtual organization shall ensure providers meet established standards and licensing/ certification requirements prior to utilizing them in the provision of services.
2. The VO will take reasonable efforts to ensure that provider credentialing remains current.
3. While providers shall not be dismissed from the network without due cause, the VO will take reasonable efforts to ensure that network providers provide safe and effective care for their beneficiaries.

## **XII. Quality Assurance**

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### **A. Quality improvement process**

1. The virtual organization will develop and implement on-line real time quality monitoring and assessment. The system will be designed to provide immediate consumer quality assessment input.
2. The VO shall have a written quality assessment and improvement plan, and an established quality improvement program.
3. The plan will include, and the program shall address, at a minimum, the following elements:
  - Service utilization (see below)
  - Care giver satisfaction and turnover
  - Participant satisfaction
  - Participant outcomes, as derived from periodic assessment data addressing the following:
    - ▶ Physiologic well being
    - ▶ Functional status
    - ▶ Cognitive ability
    - ▶ Social/behavioral function
    - ▶ Quality of life
    - ▶ Safety, efficacy, and timeliness of all services identified in the plans of care, whether clinical or non-clinical.
    - ▶ Grievances and appeals
    - ▶ The VO shall achieve minimum performance standards in each of these areas, to be negotiated between the State and HCFA, and documented in the VO agreement.
4. Continuous quality improvement should be the goal of the VO. The virtual organization will develop an ongoing quality monitoring system based on assessment data and expected values. The system should flag quality outliers. Additionally, electronic files and transactions will be available to the State or a contractor to assess ongoing quality.

### **B. Utilization, Performance/outcomes monitoring and evaluation**

1. The continuous quality improvement process must include review and documentation of the degree to which the program maximizes least-restrictive care and wellness.
2. This documentation shall include, but not be limited to:
  - Inpatient hospitalization rate
  - Institutional care utilization
  - Emergency care utilization
3. The VO shall establish one or more committees with both community and consumer representation to assess outcomes data and provide recommendations to the continuous quality improvement process.
4. The VO shall report annually to the State on its progress in achieving the stated objectives of its quality assessment plan.
5. The VO will be evaluated on its documented performance in terms of its stated objectives and the degree to which its performance exceeds past experience both within the program and the market at large.
6. The VO will be expected to submit a revised quality assurance and improvement plan to the State annually, documenting how past shortcomings will be addressed and past successes built upon.

### **XIII. Long Term Care Reform Priorities**

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#### **A. Personal responsibility**

1. Individuals who are not financially eligible for Medicaid-funded benefits will be encouraged to participate in the plan on a private pay basis. The virtual organization will create linkages to insurance companies that make it easy for the consumer to use these resources.
2. The virtual organization will work with the State to create incentives which reward individuals who have provided for their own long term care needs through insurance. Provision of care management and supports coordination will assist individuals in using resources in a manner which allows them to support their long term care needs for a longer period of time, delaying their entry to the public system, and thereby reducing the overall expenditure of public funds on their behalf.

#### **B. Housing**

1. Use of creative living environments to ensure the health and safety of plan participants will be encouraged.
2. Provision of services in assisted living and other supported living environments is expected to result in decreased health care expenditures for the target population.
3. Further, provision of services in the least restrictive, most cost effective environment will promote the simultaneous goals of cost containment and consumer satisfaction.

**C. Best practice guidelines**

1. Appropriate elements of practice guidelines established through development and implementation of the home and community based waiver program will be incorporated into contracts.
2. Practice guidelines will be provided to each plan as a basis upon which to develop local practices.

**D. Self Determination and self-directed care**

1. For individuals who are capable of and willing to manage aspects of their own care consumer-directed purchasing option will be available for the home-based long term care components of their care.
2. The virtual organization will create educational materials and electronic commerce tools that allow the customer to obtain and pay for services and provide real time feedback on resource amounts spent and amounts remaining.
3. The virtual organization through its care managers will provide education, monitoring, and coaching to insure successful self-directed care.

## **XIV. Model Evaluation Considerations (see Evaluation Section)**

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**A. Outcomes achieved:**

1. Access
2. Quality
3. Cost

**B. Model implementation integrity:**

### **C. Evaluation process:**

## **XV. Implementation Considerations**

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While the sophisticated communication systems envisioned to support the virtual long term care organization are not yet in place, many of the technological building blocks and information sets already exist in the public and private sectors. It is also clear that the virtual organization and ebusiness models are continuing to expand and mature as a way of doing business in the new millennium. However, the State will have to work with potential vendors to develop the virtual organization tool set and structures.

The State could begin developing the model without waivers, but will need "b" and "c" waivers to implement. Future integration of the Medicare benefit will require a Section 222 waiver.

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# Care Coordination Model

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## I. Introduction to the Model

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### A. Overview

The Care Coordination Model represents an evolution of the Medicaid Waiver component of MI Choice into a comprehensive long term care model, which integrates care through collaborative, team-based planning and monitoring. It unites the basic components of Medicaid managed long term care (acute/primary health care and community or facility-based long term care) and coordinates with acute/primary Medicare services by serving as the vehicle for care coordination. The model builds upon the existing long term care infrastructure which has evolved in Michigan through the Medicaid Home and Community Based Waiver Program. The Care Coordination Agency role is to create an array of long term care options through the development of public and private partnerships so that consumers have the broadest possible choice of care alternatives and providers.

Under this initiative, coordination will be achieved through active involvement on the part of the CCA and consumer in the development and implementation of treatment and care plans. For dually eligible Medicaid/Medicare consumers, the consumer's physician directs acute/ primary care activity in the treatment plan; the consumer directs long term care activity. The CCA care manager is involved with both parties as a coordinating agent to advise, monitor and initiate redirection of care and treatment plans, when appropriate. As consumers traverse the dual service systems, continuity of care arrangements will be assured by the continued involvement of a CCA care manager who has knowledge of both treatment and care plans.

### B. Core Values

1. Management of Medicaid-funded acute/primary and long term care services across all settings through establishment of voluntary coordination efforts between care coordination agent and primary care providers.
2. Creation of an array of long term options through the development of collaborative public and private partnerships that provide consumers with the broad choices of care alternatives and providers. Open vs. closed provider network.
3. Represents a continuing evolution, building upon the success of the existing Medicaid home and community-based services waiver infrastructure. Coordinates long term care services within the consumer's existing acute care provider relationship.

4. Collaborative relationships with providers, team-based care and treatment planning and monitoring.
5. Emphasis on market forces to achieve desirable outcomes and performances in areas such as cost and quality. For example, the competitive nature of the provider pool serves to promote quality and, when not constrained by artificial factors, cost control.

### **C. Unique Features**

1. Opportunity for existing waiver agencies to grow into full managing entities for the full range of Medicaid acute and long term care services.
2. Does not integrate the acute/primary care components for dually eligible consumers.
3. Managing entity will be at risk for the full range of Medicaid services for long term care consumers.

### **D. Incentives**

1. Consumer Incentives
  - Access to care manager for service coordination.
  - Retention of choice of services and providers for dual eligibles.
2. Provider incentives
  - Care coordination provides opportunity for improved cost effectiveness.
  - Cooperation with care coordination agent will improve provider understanding of each case creating opportunity for improved outcomes.

## **II. Model Locations**

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1. Site criteria
  - Each site should encompass a minimum of 2000 Medicaid long term care enrollees to achieve 500+ enrollees.
  - The area served will be comprised of one or more contiguous counties.
2. Number of sites
  - A maximum of 3 sites



### **III. Model Provider Selection**

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#### **A. Selection criteria**

1. Each application will be evaluated in terms of the following criteria:
  - Comprehensiveness of provider panel including long term and acute care providers
  - Demonstrated potential to create volunteer network
  - Clear plan for organizing as Alternative Financing Delivery System to assume risk after phase-in period
2. Selection process
  - Administrative selection based on demonstrated ability to meet established criteria and perform required functions.

### **IV. Participant Eligibility**

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#### **A. Target Population**

1. The target population of the Care Coordination Model encompasses all consumers of long term care
  - Adults with disabilities including younger adults with long term disabling conditions.
  - Individuals with dementia/Alzheimer's
  - Frail elderly
  - Individuals in need of end of life care
  - Involved families and caretakers

#### **B. Specific eligibility criteria**

1. Financial: Medicaid eligible or Medicaid/Medicare dual eligible, as currently defined by the Medicaid and Medicare programs, or:
2. Non-Medicaid eligible beneficiaries may buy-in to coverage of the Medicaid benefit as a form of long term care insurance, or:
3. The CCM may leverage other revenue sources that will allow it to serve or subsidize care for people not financially eligible for Medicaid. The CCM may use re-directed Medicaid savings for this purpose as well.

4. Medical: For Medicaid eligibles, in need of nursing home level of care.
5. Medical: For non-Medicaid eligibles, medical eligibility criteria will either be established by the funding source or the CCM.

### **C. Demographic profiles**

1. The Care Coordination Model will serve adults with disabilities aged 18 and older, and elderly aged 65 and older who have a medical necessity for long term care.

### **D. Voluntary vs. mandatory**

1. Participation will be voluntary for existing Medicaid long term care recipients.
2. Participation will be mandatory for new Medicaid recipients in the service area.
3. Private pay individuals will participate on a voluntary basis.

### **E. Geographic requirements**

1. Participants must reside within the Care Coordination Model's defined service area.

## **V. Revenue Sources**

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Medicaid acute/primary and long term care.

Revenue sources (Older Americans Act and other aging services funding, local funding, private funds) controlled by the waiver agent will be included.

Acute and primary services for Medicare funding are coordinated through efforts of the CCM care manager.

Any third party insurance carried by the beneficiary.

## **VI. Benefit Design**

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Benefits will include the full range of existing Medicaid benefits available in the primary, acute, and long term care settings. The long term care benefits will be expanded to include support for people who live in any community based residential setting including licensed AFC and Home for the Aged settings. Medicaid benefits are described in the Appendix.

Medicare funded acute care services are coordinated to the extent providers are willing to participate with the CCA in care coordinating activities.

## **VII. Administrative/Management Requirements**

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### **A. Size (covered lives and/or regional boundaries)**

1. The CCM should clearly document the number of covered lives it has determined will be necessary for its financial viability, and how it has determined that a market of sufficient size to provide this number of covered lives exists in the proposed service area.
2. The territory served must be a single county or group of contiguous counties with a minimum of 2000 Medicaid long term care eligibles.
3. Program must be administered by an existing waiver agent or collaborative effort between two or more waiver agents.

### **B. Fiduciary/corporate structure requirements**

1. Fiduciary structure
  - The CCM organization must be organized to assume risk (probably as an Alternative Healthcare Financing and Delivery System).
2. Corporate structure
  - The CCM organization must be an existing Home and Community-Based Services for the Elderly/Blind/Disabled waiver agent or a collaboration between multiple existing waiver agents.
3. The CCM shall leave a governing board with representation from community members and consumers.

### **C. Accreditation**

1. If not already accredited by a nationally recognized body, the CCM must submit an acceptable plan for achieving such accreditation.

### **D. Profit, non-profit status**

1. The managing entity of the Care Coordination Model may be for-profit or non-profit.

#### **E. MIS requirements**

1. The CCM will be required to integrate with the MI Choice Information System (MICIS), as well as complying with the reporting requirements of MDS, HEDIS, etc.
2. The CCM must also demonstrate staff capacity, availability of hardware/software necessary to integrate with MICIS and related components.

#### **F. Financial systems, claims processing**

1. If fee-for-service is used for the initial implementation period, the CCM may be required to submit shadow claims or encounter data. The CCM must be able to track access, services delivered, and cost.
2. Provider claims shall be paid in a timely fashion.
3. Administrative cost must be tracked and reported as a discrete cost category.
4. Profit or margin must be explicitly identifiable in the cost reporting system.

#### **G. Access, utilization management system/protocols**

1. CCM participants will access the program through the MI Choice Access System.
2. The CCM is expected to use management techniques incorporating assessment, monitoring and targeted care management for high cost or high needs cases and use modern information technology. Care management should be linked into the MI Choice Access process and also be linked into the quality assessment and assurance processes of the CCM.
3. Practice guidelines that model plans will be required to follow are under development.

#### **H. Organized community delivery system requirements, including collaborative agreements**

1. The CCM organization must demonstrate an established network of contracted providers with sufficient capacity to provide all required services.

#### **I. Community benefit considerations**

1. The CCM shall seek to establish services that are available to the community as a whole as well as enrolled participants, including wellness programs, preventive services, etc.

2. Coordinating community resources may streamline access even for those recipients not enrolled in the CCM.
3. Profit or margin can be reinvested in the community in the form of additional free or reduced cost service.

**J. Acute vs. community based services management relationship**

1. Medicaid acute and community-based long term care services will be fully integrated into the CCM.
2. Medicare primary and acute care services will be coordinated by the CCA to the extent that acute care providers are willing to participate with the CCA in care management activities (voluntary relationship).

**K. Consumer and family inclusion in service system design, implementation and monitoring**

1. Consumers will be involved in the development of outcome goals and measures and in grievance procedures.
2. The plan of care shall be developed using a person centered plan.
3. The CCM must have a voluntary option available to consumers to self-direct the home based long term care portions of their care.

**L. Relationship, role responsibilities relative to DCH**

1. The relationship between DCH and the CCM will be contractual in nature. The CCM will be required to provide services and supports in accordance with contractual requirements.
2. The Department of Community Health is responsible for quality oversight and fiscal and contractual monitoring of the CCM.

## **VIII. Financing Mechanisms**

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**A. Rate determination method**

1. The State will conduct an actuarially sound analysis of fee-for-service costs related to the defined service area and develop associated capitation projections.

2. The cost and capitation analysis will incorporate case mix and other adjustments such as Resource Utilization Group Score (RUGS) age, gender, and geography in the computation of rate cells.
3. The actual rate will be established through a competitive bidding process.

**B. Payment method**

1. The CCM will be paid a fixed per member per month case mix adjusted rate for all persons who are Medicaid eligible and enrolled in the plan.
2. DCH will consider phasing in the long term care and acute/primary components if desired by the CCM agency.

**C. Risk bearing strategies**

1. The CCM will bear full financial risk for all Medicaid services.
2. Stop-loss arrangements may be implemented in the initial years to risk share with the state as the capitation system is refined. Risk sharing strategies may be used based on corridors in the first year of operation.

**D. Cost containment strategies**

1. Active care management will promote timely delivery of community and preventative services designed to maintain wellness and prevent more costly acute care services.
2. Identifying a single entity responsible for coordinating services across both Medicaid and Medicare systems will result in fewer chronic health episodes and a corresponding decrease in the growth of expenditures for hospitalizations, pharmaceuticals and related health care costs.

## **IX. Customer Services**

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**A. Beneficiary rights**

1. The CCM shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions and the right to a second opinion.
2. The consumer or authorized representative shall sign and date a statement indicating that they have received an explanation of consumer rights and

responsibilities in writing, that their rights have been explained to them, and that they clearly understand.

3. These activities shall be conducted as part of the initial assessment process.
4. The CCM shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions.

## **B. Beneficiary responsibilities**

1. The beneficiary is responsible to cooperate with the efforts of the case manager to coordinate preventative, acute/primary and long term care services.

## **C. Grievances and Appeals**

1. Consumers have the right to contest decisions affecting eligibility and services. Information shall be provided that clearly explains the grievance procedures established to address the beneficiary's right to appeal the decisions made by the provider.
2. Additionally, Medicaid clients have the right to a Medicaid Fair Hearing before an Administrative Law judge when they have received an adverse decision from a Medicaid provider.
3. The CCM organization, and its contractor shall follow all applicable rules, regulations, federal laws, state law and policies related to the programs established under this proposal

## **D. Customer interests (handbook, education and training opportunities, information, etc.)**

1. The CCM organization shall develop and maintain consumer education materials designed to provide clear, concise and accurate information. Educational materials include but are not limited to a consumer handbook, bulletins or newsletters.
2. At a minimum, consumer handbook shall detail:
  - Consumer rights and responsibilities
  - Plan benefits and limitations
  - How to access providers and caregivers
  - The role of the care manager and how to access and work with the care manager to develop a care plan and receive services

- Appeals processes
- Accessing emergency care

## **X. Service Planning and Care Management**

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### **A. Coordination with MI Choice Access**

1. Individuals shall be determined medically eligible by an authorized MI Choice Access organization prior to enrollment in the Care Coordination Model. Information collected during the eligibility determination process shall be collected electronically and used as the foundation upon which further assessment and care planning activities are conducted.

### **B. Access to plan process, services**

1. Following enrollment, the CCM shall assign a primary care manager who has responsibility for coordinating access to services within the plan. A care manager shall be assigned according to individual needs and preferences.
2. While no services outside the care plan (except emergency services) will be covered, the participant shall have timely access to re-evaluation of services on demand.
3. All activities shall be conducted within established timeframes to ensure timely access.
4. If the customer opts for self-directed services, the care manager will educate the customer on self-directed care and install tools and accounts necessary to support self-directed care. The care manager will coach and monitor the self-directed care for a three-month period or as long as necessary to empower the consumer. The use of information technology will allow automated monitoring permitting timely intervention in the event of fraud or misunderstanding.

### **C. Person-centered planning process, care plan development**

1. All activities shall be conducted in the context of the person-centered plan. The development of the person-centered plan begins at enrollment. The primary care manager shall conduct an initial assessment with active participation of the consumer and others.
2. Based on assessment findings and expressed desires, the care manager and consumer develop a single plan of care that coordinates all aspects of service delivery across all care environments.



3. Consumers approve of the care plan prior to service implementation. Care managers arrange services from the consumer's provider of choice. (Consumers must have a choice of providers within the provider panel to the maximum extent possible.)
4. When the consumer selects the voluntary option for self-directed care, care managers monitor and assist the consumer in their care choices. Opportunity for self-determination include:
  - Development of care plan which must be approved by the participant.
  - Choice of provider from provider network for many services.
  - The participant may “hire and fire” home care service providers.

#### **D. Care management**

1. The assigned care coordination agent shall provide care management, follow-up and monitoring on an ongoing basis according to established protocols.
2. The care coordination agent will maintain contact with the participant, conducting in-home reassessments a minimum of every 90 days or upon significant change or participant request, to ensure the participant's health and safety in the least restrictive, most cost efficient setting.
3. The CCM organization must have established protocols for 24 hour crisis resolution in the event of a sudden change in the participant's environment (e.g. emergent illness or injury of a family care provider), such that the plan of care can be modified and necessary services provided in a timely and safe fashion.
4. Individuals and family members are encouraged to assume as many of these responsibilities for themselves as possible and desired. A variety of care management/supports coordination models are available to meet the varying needs and preferences of individuals.

#### **E. Care plan outcomes evaluation, revisions**

1. Through the person-centered plan, the participant and care coordination agent establish goals and desired outcomes at case onset.
2. Periodic, required reassessment and reevaluation of the care plan allows for adjustments and revisions as necessary to address identified needs.

#### **F. Responsiveness to community, community inclusion**

1. The CCM will make maximal use of existing waiver service coordination expertise inherent in existing waiver agents.

2. The CCM will be required to have agreements with the Area Agency on Aging, the CMH Service programs, and the Substance Abuse Coordinating agencies that specify coordination arrangements between the respective organizations.
3. It is expected that as the CCM creates its network for delivering care it will, of necessity, call on existing community resources. It is DCH's intent to create a strong link between aging and disability services and the CCM without creating overlaps in spheres of responsibility.

## **XI. Provider Network**

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### **A. Scope and capacity of provider network**

1. The CCM shall have the capacity to provide all plan benefits on a direct basis or through affiliated providers.
2. The CCM shall assemble the network, credential providers and establish subcontract agreements as necessary to ensure adequate capacity.
3. The CCM shall be responsible for paying providers in a timely fashion for authorized services at the negotiated rate.

### **B. Provider credentialing and privileging**

1. The CCM organization shall ensure providers meet established standards and licensing/ certification requirements prior to utilizing them in the provision of services.
2. The CCM organization will take reasonable efforts to ensure that provider credentialing remains current.
3. While providers shall not be dismissed from the network without due cause, the CCM organization shall take reasonable efforts to ensure that network providers deliver safe and effective care for plan beneficiaries.

## **XII. Quality Assurance**

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### **A. Quality improvement process**

1. The CCM organization shall have a written quality assessment and improvement plan, and an established quality improvement program

2. The plan will include, and the program shall address, at a minimum, the following elements:
  - Service utilization (see below)
  - Care giver satisfaction and turnover
  - Participant satisfaction
  - Participant outcomes, as derived from periodic assessment data addressing the following:
    - ▶ Physiologic well being
    - ▶ Functional status
    - ▶ Cognitive ability
    - ▶ Social/behavioral function
    - ▶ Quality of life
    - ▶ Safety, efficacy, and timeliness of all services identified in the plans of care, whether clinical or non-clinical.
    - ▶ Grievances and appeals
    - ▶ The CCM program shall achieve minimum performance standards in each of these areas.
    - ▶ In view of the ongoing development of technologies and treatment modalities, continuous quality improvement should be the goal of the CCM program regardless of how positive the outcomes are in terms of current capabilities and expectations. The CCM program should see as its mission the constant expansion of the envelope of perceived limitations to efficacy, quality, and value. While potential in any given point in time is finite, the capacity for progress in these areas should be assumed to be without limit given the necessary innovation, expansion of technology and theory, and desire to provide maximal benefit to the aging community.

### **XIII. Long Term Care Reform Priorities**

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#### **A. Personal responsibility**

1. Individuals who are not financially eligible for Medicaid-funded benefits will be encouraged to participate in the plan on a private pay basis.
2. Provision of care management and supports coordination will assist individuals in using resources in a manner which allows them to support their long term care needs for a longer period of time, delaying their entry to the public system, and thereby reducing the overall expenditure of public funds on their behalf.

3. Any third party insurance held by the participant will be the primary payer.

#### **B. Housing**

1. Use of creative living environments to ensure the health and safety of plan participants will be encouraged. Provision of services in licensed and unlicensed assisted living and other supported living environments is expected to result in decreased health care expenditures for the target population. Further, provision of services in the least restrictive, most cost effective environment will help us achieve the simultaneous goals of cost containment and consumer satisfaction.
2. Housing choice will be promoted.

#### **C. Practice guidelines**

1. Practice guidelines will be provided to each plan as a basis upon which to develop local practices.

#### **D. Self Determination and self-directed care**

1. For individuals who are capable of and willing to manage aspects of their own care it is expected that a consumer directed purchasing option be available for the home based long term care components of their care.

### **XIV. Model Evaluation Considerations (see Evaluation Section)**

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#### **A. Outcomes achieved:**

1. Access
2. Quality
3. Cost

#### **B. Model implementation integrity:**

#### **C. Evaluation process:**

## **XV. Implementation Considerations**

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The CCM does not integrate Medicare funding.

The CCM relies heavily on voluntary relationships with acute care providers and volunteer service providers. This creates a potential liability to the extent these voluntary relationships fail to materialize.

Mandatory enrollment would require a waiver if choice does not exist for alternative delivery systems.



# PACE

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## I. Introduction

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### A. Overview

Programs for All-inclusive Care of the Elderly (PACE) find their origin in the On-Lok model in San Francisco's China Town. The On-Lok project endeavored to provide a full range of both acute and long term care services to a frail elderly population in a capitated delivery and financing system that was designed to reduce the utilization of institutional care through active care management and the provision of preventive and community services. The program has now evolved into a standard long term care delivery and financing system recognized by HCFA, and provides the only means of fully integrating Medicare and Medicaid funding without a waiver.

Michigan already has a PACE program based out of Henry Ford Health System in Detroit. The experience from this PACE program demonstrates the efficacy of this long term care delivery system at reducing the utilization of institutional care while improving quality and satisfaction among a frail elderly population. However, as can be expected from any innovation, the program has not been without challenges requiring further exploration and improvement. Chief among these is the fact that it has been found that current PACE programs across the nation often appeal to a relatively narrow slice of potential enrollees as manifested by the enrollment levels experienced to date. To substantially impact long term care in Michigan, it would be desirable for delivery systems to have broader appeal than this PACE program has demonstrated.

While PACE has many attractive elements, it is not seen as a single model able to meet the needs of the entire long term care target population for an entire community. Rather, it is seen as an element of a continuum of services that each of the other models may offer to their enrollees. Therefore PACE replication will only be considered within the context of one of the other models.

It is also important to recognize that PACE operates under rather detailed federal rules and regulations. The PACE description given here is intended to reflect those federal guidelines.

Michigan is interested in more flexible and innovative approaches to PACE, particularly in areas such as applicability to broader long term care populations, feasibility in more rural areas, provision of PACE services in a residential setting such as a continuing care retirement community, and the efficacy of a more mobile approach to the site-based program (or even, a PACE without walls). Federal waivers to the existing regulations would be required in order to implement certain model innovations. Michigan is willing to apply for such if innovations are proposed that relate to the long term care objectives.

## **B. Core Values**

1. Enhance the quality of life and autonomy for frail, older adults;
2. Maximize the dignity of and respect for older adults;
3. Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and
4. Preserve and support the older adult's family unit.

## **C. Unique Features**

1. The PACE program is the only existing delivery and financing system that allows complete integration of Medicaid and Medicare funding streams. Inclusion of PACE in one of the models not only allows for exploration of the efficacy of integration of these funding sources towards creating incentives for wellness preservation, but it will also allow providers to gain experience in managing integrated funding in anticipation of more widespread opportunities in the future.
2. Under federal regulation, the PACE program provides a unique opportunity for the Medicaid program and consumers to be exempted from Medicare cost sharing and benefit limits.

## **D. Incentives**

1. Consumer Incentives
  - Centralized site-based access to a full range of medical, personal care, and social services.
  - Service delivery under a person-centered, self-directed plan of care worked out with the assistance of a multidisciplinary team of care providers.
  - Documented outcomes reflect individuals staying in their own homes, decreased use of hospital inpatient days and decreased cost of pharmaceuticals.
2. Provider incentives
  - Single, integrated funds upon receipt of separate monthly capitations per enrollee from Medicaid and Medicare.
  - Potential cost savings through Medicare cost sharing exemption.
  - Opportunity to administer a coordinated, comprehensive care plan leading to cost savings, quality improvement, and increased patient satisfaction.



## **II. Locations**

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### **A. Site criteria**

1. Since a PACE project is already running in Michigan which has demonstrated efficacy as a service delivery system, the PACE replication may be implemented as a tool in the context of a broader model (RPO, Virtual Organization, CCM or HMO—see related project descriptions).
2. As a tool incorporated into a broader model, the PACE replication project would afford the providers experience operating under a fully integrated funding stream. It is anticipated that fully integrated funding will expand in the future to incorporate other delivery systems that may prove to be of wider appeal to consumers.
3. Additionally, inclusion of the PACE replication project within the context of a broader delivery system offers certain efficiencies both to the PACE project and to the broader system including, but not limited to:
4. The PACE center can serve as a service delivery center for non-PACE participants as well, and vice versa. This may reduce the need for capital expenditure to create or adapt physical plants for service delivery.
5. Some (but not all—see below) service providers could serve both PACE and non-PACE participants, expanding the risk pool for providers (but not necessarily for the fiscal fiduciary—see below).
6. It should be noted that there would need to be clear boundaries between the PACE program and the broader model:
7. Certain providers on the multi-disciplinary team coordinating the care of PACE participants must be employees of the PACE program and serve “primarily” PACE participants. As such, these providers will not be substantially available to serve the rest of the model population.
8. Because PACE is the only HCFA recognized channel for full integration of Medicaid and Medicare funding streams and because HCFA has been hesitant to approve waivers for other integration mechanisms, additional financial firewalls between the PACE project and the fiscal fiduciary for the broader model may be required.

### **B. Size**

1. While determination of minimum enrollment necessary for financial viability of the project will be left to the applicant(s), allowance should be made for the fact that enrollment in PACE is voluntary. The National Pace Association cautions

that national experience indicate that no more than 25 percent enrollment of eligibles should be expected, and further states that national experience suggests a minimum of 250-300 covered lives (1,000 estimated eligible persons in the service area minimum) is advisable.

2. It is suggested that the eligible population be estimated using U.S. Census Data and applicable state demographic data (state will facilitate population estimation where appropriate). The eligible population is then given by:
  - Clinically Eligible \* % Financially eligible
3. Where the number of clinically eligible persons is estimated using the number of people older than 65 who have specified mobility and self-care limitations as a proxy. The percent of financially eligible is estimated by the percentage of households headed by persons 65 years and older with household incomes less than \$15,000 per year.
4. This eligible population should then be multiplied by 0.25 to give the maximum expected enrollment for the given population.

#### **C. Location**

1. Applications addressing innovative means of implementing the PACE program for residents of rural areas will be given special consideration, although it is acknowledged that federal requirements that the full range of services be provided at each and every PACE Center may inhibit rural application.
2. The State would be amenable to pursuing a federal waiver to this requirement in order to promote inclusion of rural areas in the PACE replication project.

#### **D. Number of sites**

1. The PACE replication project is expected to be a component of one or more broader models (i.e. an RPO, Virtual Organization, CCM or HMO demonstration).
2. While inclusion of PACE as a delivery component is not required for approval of a model, any or all proposed projects are welcome to do so.

### **III. Provider Selection**

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#### **A. Selection criteria**

1. Each application will be evaluated in terms of the following criteria:

2. Organizational commitment to principles consistent with the PACE model. This may be evidenced, among other things, by an organizational mission statement that indicates commitment to these values:
3. Enhance the quality of life and autonomy for frail, older adults;
4. Maximize the dignity of and respect for older adults;
5. Enable of frail, older adults to live in their homes and in the community as long as medically and socially feasible; and

**B. Preserve and support of the older adult's family unit.**

1. Evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully.
2. Evidence of experience in providing primary, acute and/or long term care services.
3. Evidence of experience in serving a dual eligible population.
4. It is desirable that the organization be familiar with the reimbursement practices and policies of both Medicaid and Medicare, as well as coordinating the services provided by these entities. Optimally, the organization will incorporate experience and expertise relating to Medicaid Qualified Health Plans and Medicare+Choice, since the PACE organization is reimbursed on a capitated basis.
5. Evidence of sufficient demand for PACE services in proposed service area (see II.A.2.a above).
6. Demonstrated financing for development and start-up. Previous PACE programs throughout the nation have spent up to \$1.5 million during the start up period due to:
7. Construction and or refitting of one or more facilities to serve as PACE centers capable of providing the full spectrum of clinical and social services required under the federal rule.
8. Possible operations deficit due to slow initial enrollment and non-scalable expenses related to facility overhead and required staffing (note again that each center must employ certain providers who serve predominantly PACE participants).

**C. Non-competition with other PACE sites.**

1. The Federal Rule prohibits overlap between the service areas of PACE organizations.
2. The supply of long term care services in the service area. This criteria encompasses two factors:
3. There must be an adequate supply of community and preventative services to effectively address the needs of the target population and avoid preventable institutional care.
4. It is desirable that the PACE program serve as a demonstrable alternative to institutional care—avoiding both the intrusiveness of institutional care on behalf of the beneficiary as well as the need to construct new facilities. One indication that this benefit is likely to be achieved could be a high occupancy rate of nursing home beds in the proposed service area.

#### **D. Selection process**

1. Proposals for PACE replication project(s) will be evaluated in the context of responses to RFPs for broader models (RPO, Virtual Organization, and/or HMO).

## **IV. Beneficiary Eligibility**

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### **A. Target Population**

1. The target population of the PACE delivery model is the frail and elderly 55 years of age and older. This is a unique feature of this program, as compared to other initiatives of the workgroup, in that the younger people with disabilities are excluded. (A PACE-like project could include a broader age range.)
2. Specific eligibility criteria (medical and financial--relates to revenue sources included)
3. Financial: Enrollees need not meet any financial eligibility criteria. However:
  - Non-Medicaid eligible enrollees may be charged a premium by the PACE program in an amount equal to the capitation that would have been paid under Medicaid, plus the amount that would have been paid under Medicare part A and/or B if the enrollee is also not eligible for State payment for one or both of those programs.
  - Medicaid eligible enrollees may not be charged a premium, regardless of their Medicare eligibility status.
  - Non-dual eligibles (i.e. Medicaid-only): The federal rule implies (by way of the above prohibition of premiums) that HCFA anticipates some states may want to

offer PACE as an option to individuals eligible for only Medicaid (the Medicaid program is already financially liable for both long term and acute care for these individuals). It will need to be determined whether the State Medicaid program desires to make this an option within the replication site.

- Medical: In need of nursing home level of care.
- Age: 55 or older

## **B. Demographic profiles**

1. The PACE organization will serve frail elderly adults aged 55 and older who have a medical necessity for long term care services.
2. Beneficiaries will be predominantly financially eligible for Medicaid and Medicare because of the demographics of this population, but they need not be eligible for either to participate.

## **C. Voluntary vs. mandatory**

1. Participation will be voluntary.

## **D. Geographic requirements**

1. Participants must reside within the PACE organization's defined service area.

# **V. Revenue Sources**

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Any third party insurance carried by the beneficiary.

Medicaid and Medicare capitation payments for enrollees eligible for one or both of these programs

Enrollee premium payments for non-Medicaid eligibles (see IV.B.1)

# **VI. Benefit Design**

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This model provides the full range of Medicare and Medicaid benefits including primary, acute and long term care. The description of the benefits included in the PACE model is included in the Appendix.

The following services are excluded from coverage under PACE:

- Any service that is not authorized by the multidisciplinary team, even if it is included in the list of required services, unless it is an emergency service.
- In an inpatient facility, private room and private duty nursing services (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the multidisciplinary team as part of the participant's plan of care).
- Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
- Experimental medical, surgical, or other health procedures.
- Services furnished outside of the United States, except as follows:
  - Certain services rendered under emergency circumstances
  - As permitted under the State's approved Medicaid plan.
- Through the RFP process applicants will be encouraged to provide services focused on wellness and information that are valued by the target population.

## **VII. Administrative/Management Requirements**

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### **A. Size (covered lives and/or regional boundaries)**

1. Sufficient eligible population (factoring in 25 percent participation rate) to ensure fiscal viability. The National Pace Association states that national experience suggests a minimum of 250-300 covered lives (1,000 estimated eligible persons in the service area minimum) is advisable.

### **B. Fiduciary/corporate structure requirements**

1. Fiduciary structure
2. A PACE organization must be wholly or a distinct part of an entity of city, county, State, or Tribal government or
3. A private, not-for-profit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986.

4. Corporate structure
5. The applicant must submit an organizational chart indicating the presence and supervisory role of at least the following:
6. Program Director (responsible for oversight and administration)
7. Medical Director (responsible for delivery of care and quality assessment/improvement)
8. Governing Body (responsible for policy development, governance, and fiscal operations)
9. Community representation (for example, on governing board)
10. Consumer advisory committee

**C. Accreditation**

1. All participating providers must be licensed, certified and/or accredited as required under state and federal law for their scope of practice.
2. Further, the performance of the PACE project will be evaluated per the federal rule through annual data submission to State and Federal government entities.

**D. Profit, non-profit status (including administrative cost/cap)**

1. The federal rule requires that the PACE organization be a government or non-profit entity.

**E. MIS requirements**

1. The PACE organization will be required to utilize MI Choice Information System (MICIS).
2. The organization must also demonstrate staff capacity, availability to hardware/software necessary to support MICIS and related components.

**F. Financial systems, claims processing**

1. The PACE organization administers the program by receiving the separate capitations and melding them in to a single reimbursement stream.
2. The PACE organization employs certain members of the multidisciplinary care team and other providers and the PACE center, as well as other providers as it

sees fit. Non-employee, contracted network providers will be reimbursed by the PACE organization at negotiated rates for services authorized under the plan of care.

3. Out of network providers will only be reimbursed for emergency services.
4. All providers accepting payment from the PACE organization shall accept such payment as payment in full.
5. No payment shall be made on claims for services not authorized under the plan of care (or pre-approved by the PACE organization in the event of urgently needed out-of-network and/or post-stabilization care) unless they are emergency services (except in the event of urgently needed out-of-network and/or post-stabilization care if the PACE organization fails to respond to a pre-authorization request within 1 hour).

**G. Access, utilization management system/protocols**

1. Utilization management shall be accomplished by means of a care plan, authorized by and developed in coordination with the recipient under the guidance of the multidisciplinary team.
2. Care management should be linked into the Access process and also be linked into the quality assessment and assurance processes of the PACE organization.
3. Access flow chart and practice guidelines are under development.

**H. Organized community delivery system requirements, including collaborative agreements**

1. The PACE organization must demonstrate an established network of contracted providers with sufficient capacity to provide all required services.
2. Particular favor will be shown to those applicants who demonstrate the potential for a network of providers of sufficient size to maximize continuity of care for those beneficiaries already receiving specialty care
3. Note that primary care services must be provided by the primary care provider(s) employed by the PACE organization, who serve primarily PACE participants).
4. However, the Department would support an application for waiver of this requirement if such wavier would demonstrably increase the appeal of the proposal to consumers while not compromising quality
5. The Financial and service delivery relationship between the PACE program and the larger model should be clearly delineated and constructed with a view towards



maximizing mutual benefit and efficiency within the parameters of the federal regulations.

**I. Community benefit considerations**

1. The required PACE center(s) will provide a focal point for education, prevention, and other health services. While not required, it is conceivable that various social events, educational events, and certain health interventions (such as influenza vaccination) could be shared with the community at no or reduced cost.
2. The PACE program provides an inherent community benefit by allowing the communities to continue to benefit from the presence of their elder members.

**J. Acute vs. community based services management relationship**

1. Active care management, coordinated by the multidisciplinary team in keeping with the plan of care prepared in cooperation with and approved by the participant, will be designed to ensure timely referral to the most appropriate, least disruptive community based and preventative services.
2. Acute care will be managed by the same corporate entity that manages community based services, maximizing the coordination of services and minimizing disincentives to wellness preservation.
3. In addition, the same physician that managed community-based services through the team will manage acute care. This involvement of medical expertise in care management is a unique strength of the model.

**K. Consumer and family inclusion in service system design, implementation and monitoring**

1. The PACE organization will be required to involve consumers in significant and substantial ways. This will occur through its governing board, in the development of outcome goals and measures and in grievance procedures.
2. The federal rule requires community representation in the administration of the PACE organization as well as the establishment of a Consumer Advisory Committee to advise the Governing Board.

**L. Relationship, role responsibilities relative to DCH**

1. The PACE program will operate as a component of the master contract between the Department of Community Health and the fiscal fiduciary of the long term care model.

- M. The PACE program will be subject to all terms of participation under Medicaid and Medicare.**

## **VIII. Financing Mechanisms**

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### **A. Rate determination method**

1. The PACE organization will be paid a capitated rate in the same manner as our existing PACE model in Detroit (details to follow).
2. For Medicare eligibles, the Federal government will also pay a capitation (thereby reducing the effective covered services and capitation rate paid by the state for these individuals) to the PACE organization.
3. The capitation rate will be that paid to Medicare+Choice managed care plans under Parts A & B (where applicable). This payment will be mix adjusted, multiplying the Medicare+Choice base rate by a frailty factor to adjust for the high needs of this population.
4. Currently, the frailty factor is 2.39.
5. A risk-based adjusted capitation system will be implemented in the future (perhaps FY 2001), similar to the risk based adjustment system utilized for the Medicare+Choice program as of January 1, 2000.
6. Medicaid capitation rates will be case-mix adjusted at some future date.

### **B. Payment method**

1. The PACE organization will be paid a fixed per member per month for all persons who are Medicaid eligible and receiving services.

### **C. Risk bearing strategies**

1. The PACE organization will bear full financial risk.
2. The PACE models shared risk with HCFA during phase-in, but this is not a provision of the new PACE program under the federal rule.

### **D. Cost containment strategies**

1. Active care management, intensive adult day care and multi-disciplinary team approach will promote timely delivery of community and preventative services designed to maintain wellness and prevent more costly acute care services.
2. Integration of Medicaid and Medicare capitations removes the incentive for cost and responsibility shifting and creates incentives for health maintenance.

## **IX. Customer Services**

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### **A. Beneficiary rights**

1. The PACE shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions and the right to a second opinion.
2. The consumer or authorized representative shall sign and date a statement indicating that they have received an explanation of consumer rights and responsibilities in writing, that the rights have been explained to them, and that they clearly understand.
3. These activities shall be conducted as part of the initial assessment process.
4. The virtual organization shall create information materials and tools to inform consumers of rights and responsibilities under the plan, including the right to appeal adverse coverage decisions.

### **B. Beneficiary responsibilities**

1. The beneficiary is responsible to cooperate with the efforts of the case manager to coordinate preventative and community based services.

### **C. Grievances and Appeals**

1. Consumers have the right to contest decisions affecting eligibility and services. Information shall be provided that clearly explains the grievance procedures established to address the beneficiary's right to appeal the decisions made by the provider.
2. Additionally, Medicaid clients have the right to a Medicaid Fair Hearing before an Administrative Law judge when they have received an adverse decision from a Medicaid provider.

3. The PACE organization, and its contractor shall follow all applicable rules, regulations, federal laws, state law and policies related to the programs established under this proposal

**D. Customer interests (handbook, education and training opportunities, information, etc.)**

1. The PACE organization shall develop and maintain consumer education materials designed to provide clear, concise and accurate information. Educational materials include but are not limited to a consumer handbook, bulletins or newsletters. At a minimum, consumer handbook shall detail:
  - Consumer rights and responsibilities
  - Plan benefits and limitations
  - How to access providers and caregivers
  - The role of the interdisciplinary team and how to access and work with the interdisciplinary team to develop a care plan and receive services
  - Appeals processes
  - Accessing emergency care

## **X. Service Planning and Care Management**

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**A. Coordination with MI Choice Access**

1. Individuals shall be determined medically eligible by an authorized MI Choice Access organization prior to enrollment in the PACE.
2. Information collected during the eligibility determination process shall be provided electronically to the PACE organization to be used as the foundation upon which further assessment and care planning activities are conducted.

**B. Access to plan process, services**

1. Screening and enrollment: Eligible individuals residing in the service and electing to receive services through the PACE program will be screened, evaluated, and enrolled (flow chart of consumer access and enrollment process under development)
2. Following enrollment, the individual will be assigned to a multi-disciplinary care management team, which shall contact the individual by phone within 24 hours

and in person within 72 hours in order to assist the enrollee is developing a plan of care.

### **C. Person-centered planning process, care plan development**

1. All care planning and service delivery shall be conducted in a person-centered manner. The person-centered planning process begins at enrollment. The multidisciplinary team shall conduct an initial assessment with active participation of the consumer and others, as deemed appropriate or necessary.
2. Based on assessment findings and expressed desires, the multidisciplinary team and consumer develop a single plan of care that coordinates all aspects of service delivery across all care environments.
3. Consumers approve of the care plan prior to service implementation. The multidisciplinary teams arrange services from the consumer's provider of choice, where possible (certain members of the multidisciplinary team, including the primary care provider, must be employed by the PACE organization and serve primarily PACE participants).
4. Opportunity for self-determination include:
5. Development of care plan which must be approved by the participant.
6. Choice of provider from provider network for many services.
7. Female participants may select a women's health specialist for primary care in lieu of the PACE organization's primary care provider.

### **D. Care management**

1. The assigned multidisciplinary team shall provide care management, follow-up and monitoring on an ongoing basis according to established protocols.
2. The multidisciplinary team will maintain contact with the participant, conducting in-home reassessments a minimum of every 90 days to ensure the participant's health and safety in the least restrictive, most cost efficient setting.
3. The multidisciplinary team must conduct an in-person reassessment in the event of a change in the participant's health or functional status or at the request of the participant.
4. The PACE organization must have established protocols for 24 hour crisis resolution in the event of a sudden change in the participant's environment (e.g. emergent illness or injury of a family care provider), such that the plan of care can be modified and necessary services provided in a timely and safe fashion.

#### **E. Care plan outcomes evaluation, revisions**

1. Through the person-centered planning process, the participant and multidisciplinary team establishes goals and desired outcomes at case onset.
2. Periodic, required reassessment and reevaluation of the care plan (at least once every 90 days, or at the beneficiary's request) allows for adjustments and revisions as necessary to address identified needs.

#### **F. Responsiveness to community, community inclusion**

1. PACE organizations are required by law to have consumer representatives on their governing Boards. Through the application process, PACE organizations will need to document agreements with the Area Agency on Aging, the CMH Service programs, and the Substance Abuse Coordinating agencies. As the PACE organizations create their networks for delivering care they will of necessity call on existing community resources. It is DCH's intent to create a strong link between aging services and the long term care PACE organization without creating overlaps in spheres of responsibility.
2. Furthermore, the PACE organization shall provide ample opportunity for the inclusion of other existing community long term care service providers that provide services included in the benefit package of the plan.

### **XI. Provider Network**

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#### **A. Scope and capacity of provider network**

1. The following members of the multidisciplinary team must be employed at each PACE center and serve primarily PACE participants:
  - Primary care physician
  - Registered nurse
  - Social worker
  - PACE center manager
  - Home care coordinator
  - Recreational therapist or activity coordinator
  - Personal care attendant
  - The PACE organization shall have the capacity to provide all plan benefits on a direct basis or through affiliated providers.
  - The PACE organization shall assemble the network, credential providers and

establish subcontract agreements as necessary to ensure adequate capacity.

- The PACE organization shall be responsible for paying providers in a timely fashion for authorized services at the negotiated rate.

#### **B. Provider credentialing and privileging**

1. The PACE organization shall ensure providers meet established standards and licensing/ certification requirements prior to utilizing them in the provision of services.
2. The PACE organization will take reasonable efforts to ensure that provider credentialing remains current.
3. While providers shall not be dismissed from the network without due cause, the PACE organization shall take reasonable efforts to ensure that network providers provide safe and effective care for their beneficiaries.

## **XII. Quality Assurance**

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#### **A. Quality improvement process**

1. The PACE organization shall have a written quality assessment and improvement plan, and an established quality improvement program
2. The plan will include, and the program shall address, at a minimum, the following elements:
  - Service utilization (see below)
  - Care giver satisfaction and turnover
  - Participant satisfaction
  - Participant outcomes, as derived from periodic assessment data addressing the following:
    - ▶ Physiologic well being
    - ▶ Functional status
    - ▶ Cognitive ability
    - ▶ Social/behavioral function
    - ▶ Quality of life
    - ▶ Safety, efficacy, and timeliness of all services identified in the plans of care, whether clinical or non-clinical.
    - ▶ Grievances and appeals

- ▶ The PACE program shall achieve minimum performance standards in each of these areas, to be negotiated between the State and HCFA, and documented in the PACE program agreement.
- 3. In view of the ongoing development of technologies and treatment modalities, continuous quality improvement should be the goal of the PACE program regardless of how positive the outcomes are in terms of current capabilities and expectations. The PACE program should see as its mission the constant expansion of the envelope of perceived limitations to efficacy, quality, and value. While potential in any given point in time is finite, the capacity for progress in these areas should be assumed to be without limit given the necessary innovation, expansion of technology and theory, and desire to provide maximal benefit to the aging community.

#### **B. Utilization evaluation**

1. The continuous quality improvement process must include documentation of the degree to which the program maximizes least-restrictive care and wellness.
2. This documentation shall include, but not be limited to:
3. Inpatient hospitalization rate
4. Institutional care utilization
5. Emergency care utilization

#### **C. Performance/outcomes monitoring and evaluation**

1. The PACE program shall establish one or more committees with both community and consumer representation to assess outcomes data and provide recommendations to the continuous quality improvement process.
2. The PACE program shall report annually to the State and HCFA on its progress in achieving the stated objectives of its quality assessment plan.
3. The PACE program will be evaluated on its documented performance in terms of its stated objectives and the degree to which its performance exceeds past experience both within the program and the market at large.
4. The PACE program will be expected to submit a revised quality assurance and improvement plan to the State and HCFA annually, documenting how past shortcomings will be addressed and past successes built upon.



### **XIII. Long Term Care Reform Priorities**

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#### **A. Personal responsibility**

1. Individuals who are not financially eligible for Medicaid-funded benefits will be encouraged to participate in the plan on a private pay basis. Provision of care management and supports coordination will assist individuals in using resources in a manner which allows them to support their long term care needs for a longer period of time, delaying their entry to the public system, and thereby reducing the overall expenditure of public funds on their behalf. In addition, utilization of care management services will delay or prevent morbidity, improving the beneficiary's quality of life.

#### **B. Housing**

1. Use of creative living environments to ensure the health and safety of plan participants will be encouraged. Provision of services in assisted living and other supported living environments is expected to result in decreased health care expenditures for the target population. Further, provision of services in the least restrictive, most cost effective environment will help achieve the simultaneous goals of cost containment and consumer satisfaction.

#### **C. Best practice guidelines**

1. Best practice guidelines for the models are under development.

#### **D. Self-directed Care**

1. Due to the constraints of federal regulations and the financial risk born by the organization, the PACE model may not be amenable to self-directed care.
2. However, the cooperative development of a plan of care will promote consumer-directed service delivery.

### **XIV. Evaluation Considerations (see Evaluation Section)**

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#### **A. Outcomes achieved:**

1. Access
2. Quality

### 3. Cost

#### **B. Model implementation integrity:**

#### **C. Evaluation process:**

## **XV. Implementation Considerations**

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Enrollment in other PACE programs throughout the nation has been limited. One substantial barrier to enrollment is the need to change providers if existing providers are not in the PACE network, particularly since the primary care physician must be a PACE direct employee and work primarily for the PACE program. Applicants are encouraged to address this issue with creativity.

The opportunity for innovation in delivery of services within the PACE construct is limited to an extent by federal regulation, although there is some (as yet untested) room for variance through waivers.

## Evaluation of the Models and Outcomes

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### Overview

The long term care evaluation is intended to compare across models, compare across four sub-populations (frail elderly, persons with dementia, young disabled, end of life); between baseline and quarterly follow-ups; and between model participants and comparison group members drawn from other counties and, perhaps, other states.

Data for most questions are likely to come from Michigan's rich set of on-going data sources for long-term care populations including the MI CHOICE/MICIS data, MDS data from nursing homes, and other sources such as nursing home cost reports and Medicaid claims data, and from national data sets such as the Medical Expenditure Panel (MEPS) and the national death index. In some cases, participants and controls will have data available for relatively long baseline periods, which have already begun for some enrollees or may begin before Phase One is implemented.

Primary data collection (i.e., directly from models and/or participants) on a sample of participants and a sample of control group waiver clients will be required for assessment of effects on self-determination and changes in the extent to which care choices are consumer-driven. Comparison group data on self-determination might be available from RWJF projects for some subpopulations. Primary data collection will also be required for assessment of quality of life, satisfaction with care, and informal caregiver outcomes such as burden, stress, and satisfaction.

Benefits of treatment tend to be greatest early in a participant's experience, declining after continued participation, especially beyond one year. Experience suggests that collection of primary data, and cost data, should wait until the program has reached a steady state. The evaluation begins at the end of year one of Phase one and continues for two years. However, the evaluation contract should begin one month before the study period and continue for five months after the two-year study to allow time for final data acquisition, analysis, and reporting.

Given past experience in home care studies, expectations should be modest. Priority in the evaluation efforts should be placed on improving participant and informal caregiver satisfaction and participant self-determination.

Overall questions on outreach, intake, assessment, level of care and eligibility determinations are not applied to the models but should be asked separately of the MI Choice access process and the entities which perform those functions (likely a separate evaluation). However, the models will be expected to accept and retain dually eligible consumers and will be evaluated for their success in accepting them and in altering their utilization patterns and outcomes.

## **I. Research Questions**

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Specific research questions will include:

### **A. Access**

1. Is the target population being served? Measures:
  - What is the penetration rate (numbers served per numbers estimated to be in service area)?
  - How does the case mix being served compare to the case mix estimated to be in the population? In the nursing homes? To similar settings in other states? What are turnover rates, lengths of stay, discharge, and re-enrollment rates? Have the models succeeded in accepting and retaining dually eligible consumers?
2. Does the model meet physical accessibility standards? Measures:
  - Are the facilities and vehicles the model uses barrier-free?
  - Does the model meet geographic accessibility standards? (e.g., 30 miles or 30 minutes by public transportation)
  - Are individuals/families satisfied with the convenience and location of services?
3. Are services culturally competent? Measures:
  - What is the penetration rate among ethnic minorities? (Numbers served per number estimated to be in service area). Are interpreter services, and alternative language materials (Braille) available?
  - Are individuals/families satisfied with cultural responsiveness?
4. Does the model meet timeliness standards? Measures:
  - What is the average number of days from time of referral to contact and from contact to initiation of service planning?
  - What is the average number of days from initiation of planning to commencement of services?
  - Are individuals/families satisfied with the timeliness of service commencement?
5. Does the model provide access to an integrated, comprehensive set of community-based services? Measures:
  - How does the network of services used through the model (including those directly provided as well as those arranged) compare with the actual constellation of services and supports available in the community?
  - What methods are employed to assure that individuals/families get the services they need and when they need them (e.g., recruitment and development of

provider network, strategies to prevent or reduce staff turnover, evidence of coordination and/or agreement among community agencies, timeliness of referral to commencement of services)?

- Is the network of services sufficient and flexible enough to meet consumer/family’s current and changing needs?
- Is access to housing alternatives available when needed and desired?
- Does the model improve access to acute/primary care without over-reliance on emergency room visits?
- What evidence is there of coordination with acute/primary care providers?
- Are individuals/families satisfied with the array and intensity of services they receive?

## **B. Quality of Care**

1. Is the care provided by the model “consumer-driven”? Measures:

- How are individuals/families involved in care planning? (Who is present during planning? who is in charge? How are preferences, desires, and goals, solicited?)
- Do options exist for individuals to be their own case manager or to select a family member to do so? Is training available to assist them in being a care manager?
- Is there evidence of consideration and use of social integration, least restrictive environment, and community-based care?
- How are individuals/families informed of the choices they have of services and providers?
- Are individuals/families satisfied with their involvement in care planning?

2. Does the care provided meet standards of practice? Measures:

- What treatment modalities are used for the condition and how do they compare with standards of practice?
- Is the care and treatment provided by qualified staff? Is the number of institutional staff adequate? Are amenities improved? Is discharge-planning effective?
- Are measures taken to prevent disease or excess disabilities? (e.g., health and safety precautions, wellness strategies)
- Do the issues identified in assessment get addressed in planning?
- What measures are taken to monitor health?
- To what extent is the variation in care used explained by patient risks?

3. Are the models successful in identifying, serving and retaining an appropriate population (including the dually eligible) with an appropriate and well integrated set of culturally competent, reliable, high quality services delivered in a timely manner?
4. Is there an internal quality assurance/improvement program? Measures:
  - Licensing and/or accreditation of network providers?
  - How does the model track performance of sub-contractors?
  - How does the model assure quality of providers? (Credentialing, background checks)
  - Are there orientation and training of new employees, training of continuing employees?
  - How does model track complaints, critical incidents, sentinel events, and make improvements based on analysis?
  - How is the input of individuals, families, and advocates obtained and used to make improvements in service delivery?
5. What is the role of utilization review and management (UM) in the models? Measures:
  - How is UM used to limit the use of high cost services?
  - To what extent does UM apply treatment guidelines, protocols, and judgment to determine if services are appropriate and necessary? Do they reduce unexplained variation in use compared to the control group?
6. Is the grievance and appeals process in place and used? Measures:
  - Is there a written policy?
  - How are individuals/families informed of their rights to grievance and appeals?
  - Is there evidence that written notice has been given when services are denied, reduced, or terminated?
  - Have individuals/families used the process?
  - Do individuals/families know of their rights?
  - Are individuals/families who used the process satisfied with the outcome?

**C. Outcomes-Individual: (Note: these will be individual - e.g., job or independence for young disabled; improved health or socialization for frail elderly; postponement of nursing home admission for persons with dementia, etc.)**  
**Measures:**

1. Is there improvement or maintenance of participant and caregiver life satisfaction, satisfaction with care, and other measures of caregiver benefits;
2. Is there reduction of participants' unmet need, increased use of preventive services, and improvements or maintenance in other condition-specific outcomes and care plan goals for specific patients or subgroups, such as: hygiene, appetite, nutrition, weight, depression, medication compliance, sleep patterns, pain control, skin condition, living environment (e.g., removal of hazards; installation of smoke detectors; emergency plan in place; telephone accessible and usable; home repairs made), dental health, social interaction and relationship with informal caregivers and others; and improvements in end-of-life specific measures of optimal care.
3. Are there improvements in institutional care quality including patient outcomes in relation to trajectories and expected values?
4. Improvement or maintenance in participant self-determination, the extent to which care choices are consumer-driven, and policies and practices are Olmstead-compliant in provision of community based service options to clients who qualify for institutional care;
5. Improvement or maintenance in activity levels, reduction in isolation, and in mental and/or physical health and social status;
6. Improvement or maintenance of mobility or physical or mental function or mortality.
7. Equivalent or superior performance on [two-three] selected outcomes compared with selected standard outcome measures? (To the extent the outcome was desired and indicated in planning.)

#### **D. Outcomes-System Measures:**

1. What were the impacts upon use? Was there at least limited impact upon hospital admission and emergency room visits achieved? Were event histories improved such as time until first hospitalization, subsequent hospitalizations, relative to fee-for-service control group dates of outcome?
  - What is the evidence that resources are being re-directed away from nursing home placements and into either serving more people and/or adding more services and/or service capacity?
  - How many people are successfully transitioned from nursing homes into the community?
  - How does proportion of persons entering community LTC compare with the proportion of persons entering nursing homes (case mix adjusted)?

2. Is nursing home case mix, length of stay or discharge status of nursing home patients affected?
3. Is there evidence of improved care planning, and are care plans better explained by patient risks and needs than in comparison groups' experience?
4. If new users are drawn into the models, are they appropriately served with services adjusted to their needs and risks?

#### **E. Cost and Efficiency Measures:**

1. Are the models cost effective?
  - [Using both regression-based and actuarial methods] Are per capita and aggregate costs no higher than those of the comparison groups?
  - Were cost increases, if any, no more than modest relative to the control group (after costs have reached a steady state).
  - Were cost increases, if any, offset by increased value in the form of improvements in patient and caregiver satisfaction, self-determination and other patient or informal caregiver outcomes. (In some models, informal caregivers may come to be paid attendants but should continue to be regarded as informal caregivers for purposes of evaluation of models' benefits).
  - If higher, to what can the excess spending be attributed? (e.g., regional wage rate differences, improved outcomes, etc.)
  - To what extent are there savings in acute/primary health care and in what areas? To what is this attributed, e.g., pharmacy prices or use, nursing home prices or use, etc?
  - What are the cost savings to Medicaid and Medicare?
  - How do the administrative expenditures compare with the direct care expenditures?
2. To what extent is private pay being used? Long-term care insurance? Other funding sources?
3. Did the negotiation process for selecting providers into networks result in lower prices for care and services?
4. Management information system (demographic and service utilization, cost). Measures:
  - Does the model submit all data as required by MDCH, encounter data reporting each discrete home care and other services?
  - Is the data accurate (less than 5 percent error rate), in the formats and cycles required, and on time?



- Are care planning and service use data linked?
- Does the information system of the model permit cost analysis and tracking on a least a monthly basis, monitoring service use patterns, variation by case manager teams, geographic location, etc.?
- Does the information system of the model have procedures for detecting fraud and abuse?
- Is the information system used to make internal management decisions?
- Do data collected and provided by the models meet evaluators' needs?

5. Models' Management capability. Measures:

- Are the models appropriately and efficiently management?
- Are they staffed by individuals who are available, adequate, qualified and well supervised?
- Is there is adequate infrastructure to maintain effective quality improvement and information systems functions?
- Are participants and caregivers treated as partners in model decision-making?
- Effective use of timely and accurate management information to monitor effectiveness and efficiency, provide feedback, and evaluate success in achieving model objectives.

## **F. Implementation Models' Unique Features**

1. What are each model's unique features, what specific promise does it offer, was that feature implemented and did it produce the effects desired? Measures:
  - Virtual model
    - ▶ Success in transferring technology to consumers.
    - ▶ Responsiveness to problems, cultural competency in adapting to special needs of subpopulations, effectiveness of ombudsman or consumer response staff.
    - ▶ Strategies to protect users from depersonalization. Human back up.
    - ▶ Innovative use of technology, new services introduced, incorporation of consumer suggestions.
    - ▶ Monitoring which technologies work best: web TV, computer-based access, phone.
    - ▶ Privacy protection.
    - ▶ Links to community organizations, associations, and advocacy groups.
    - ▶ Contract and risk sharing arrangements, appropriateness of incentives.

- ▶ How licensed: HMO or AFID (Alternative Financial and Delivery System)
- ▶ Links to the target population.
- ▶ Integration of care for dually eligibles.
- Regional Provider Organization
  - ▶ Which organizations are involved in the network, how are they linked to the community, how do they communicate, how do they spread risk, appropriateness of incentives, links to the target population.
- HMOs
  - ▶ Access barriers, de-selection methods, if any?
  - ▶ Efficiency: how do they negotiate lower prices, and with what consequences for service scope and quality?
  - ▶ Extent to which they employ early intervention and substitute services to forestall more expensive services?
  - ▶ Methods of discouraging use of expensive or ineffective services.
  - ▶ Provider panel selection and monitoring; appropriateness of incentives?
  - ▶ Use of case management and targeted case management?
  - ▶ Solvency and reinsurance – timeliness of provider payment?
  - ▶ Payer source integration, including dually eligible and private payment.
- Care Coordination Model
  - ▶ Comprehensiveness of the network; options for consumers.
  - ▶ Communication methods, service integration.
  - ▶ Risk distribution, incentives, monitoring.
- PACE
  - ▶ Adaptations to the basic PACE model, e.g., new settings other than day care?
  - ▶ Enrollment success.

## II. Data Sources

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### A. Secondary Data Sources

1. Data to measure all outcomes except satisfaction, caregiver burden, and self-determination at baseline and follow-up and between the treatment and control groups should come principally from model reporting requirements, and the

waiver programs. These should be routinely collected data, processed, stored and reported by the management information systems of the models and the waiver programs and provided without charge to the evaluators. The sources include:

- MI CHOICE/MICIS data collected on all waiver clients at client assessment and at regular intervals.
- MDS data collected on nursing home clients at assessment, annually and whenever there is a major status change.
- National data sets such as the medical expenditure panel (MEPS), a national probability household sample collected approximately 3 years ago and now being released, and the national death index.
- Michigan data warehouse data.
- Nursing facility cost report database.

## **B. Primary data collection**

1. In-person interviews regarding life satisfaction, satisfaction with care, caregiver burden, and feelings of self-determination at baseline and annual follow-ups with a sample of model enrollees and family caregivers, and waiver clients and waiver client family caregivers not enrolled in the models.
2. Descriptive case study interviews conducted with model program directors, staff and case managers.
3. Abstraction of care program policy manuals, staff training, budget documents, cost reports, care planning guidelines, care plans, and other program documents.

# **III. Samples**

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## **A. Participant and Caregiver Samples**

1. A treatment group sample of persons will be drawn to represent new enrollees in a model program after the one-year anniversary date of start-up of model operations. The sample will consist of all enrollees at each model and each model site. Members will be identified upon enrollment as they move into the models for the following 12 months. Each sample member's utilization, outcomes and costs data will be collected for one year following assessment.

## **B. Satisfaction, Caregiver and Self-Determination Sub-samples**

1. A treatment group sub-sample of enrollees and their caregivers drawn proportionate to enrollment size at each model site will be interviewed at baseline

and one-year follow-up to capture change in satisfaction, caregiver burden, and perceptions of self-determination of care choices.

### **C. Control Group Waiver Client and Caregiver Sample**

1. A control group sample will be drawn from among waiver clients in counties matched to those with model programs.

### **D. Satisfaction, Caregiver and Self-Determination Sub-sample**

1. A sub-sample of control group members and their family caregivers will be drawn from the full control sample.

## **IV. Research Design and Analytical Approach**

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A quasi-experimental pretest-post-test, treatment-control group design will be employed. Model-by-model differences between model enrollees and control group waiver clients will be evaluated with the following with iterations of the following general model:

$$y = b_0 + B_1x_{11-n\text{-groupassignment}} + B_2x_2\text{demographic} + B_3x_3\text{diagnostic} + B_4x_4\text{physicalfunction} + B_5x_5\text{mentalfunction} + B_6x_6\text{prioruse} + B_7x_7\text{-xnnotherconditions} + \text{error}$$

where:

y = change from baseline to follow-up in any of several outcomes such as physical function, skin condition, caregiver satisfaction, perceived self-determination, etc.

$x_{11-n\text{-groupassignment}}$  = specific model or control group assignment

Since multiple outcomes will be tested, significance will have to be evaluated conservatively to avoid multiple comparison effects (e.g., if alpha is set at .05, one of every 20 comparisons will be significantly different by chance alone).

## Federal Waivers

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The Health Care Financing Administration (HCFA) has statutory authority to waive particular federal laws and regulations that govern Medicare and Medicaid. States must make application to HCFA for a waiver. For Medicaid funding, a waiver is essential if the State intends to collect the federal share of the cost for any services provided through programs that do not follow established rules. Many of the recommendations in this report, particularly including the long-term care models, would require a waiver in order to collect the federal share of the Medicaid cost.

In general, there are two types of Medicaid waivers that can be provided by HCFA: “program” waivers and “research and demonstration” waivers. In contrast to the research waivers, which can be quite broad in scope and permit experimentation in many areas, program waivers are usually more limited in scope. In the Medicaid program, there are two types of program waivers. These are the home and community based service (HCBS) waivers and freedom of choice (FOC) waivers.

The most relevant Medicaid waivers for Michigan to consider relative to the long term care models appear to be the Section 1115 waivers and the Section 1915 waivers.

Section 1115 waivers are research and demonstration waivers. Under these waivers, states are no longer required to follow a variety of standard Medicaid requirements in order to test ideas and new policies. Each waiver is time-limited. Research and demonstration waivers have a far more complex application process than program waivers, and tend to take considerably longer (often literally years) to negotiate and eventually approve. They also have very extensive formal evaluation requirements. Initial Section 1115 waivers do not have a time limit. The time frame for initial waivers is determined by HCFA as deemed appropriate. Waiver renewals are limited to three year extensions.

Section 1915(b) waivers are the Medicaid freedom-of-choice waivers. They permit a state to waive beneficiaries’ rights to select their own Medicaid providers, comparability of services, and the requirement to make any service provided available statewide. These also allow states to place beneficiaries in primary care case management programs (PCCM), which are administered on a managed fee-for-service basis, or in a prepaid capitated arrangement. The latter type of arrangement can involve mandatory enrollment in HMO’s, health insuring organizations, or prepaid health plans. They are approved for two year intervals, and may be reauthorized by HCFA.

Under Section 1915(c), states may request waivers of certain federal requirements which impede the development of Medicaid-financed community-based treatment alternatives. The waiver application must specify the types of services to be provided, the target population/s and the areas of the state in which these services will be provided. Under these waivers, states have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve. States can waive statewideness, comparability of

services and certain income and resource rules under these waivers. Section 1915(c) waivers are for an initial period of three years and may be extended for periods of five years

1915(b) and (c) waivers in combination are probably the most fruitful route for Michigan. It is the pattern most recently used by the Texas Star Plus program and Michigan's mental health waiver. The combination 1915(b) and (c) waiver overcomes the problem of HCFA delays in the approval process since the granting of waivers is governed by a set time frame to which HCFA has to adhere. The 1915 waivers are the most used and therefore the ones with which HCFA is most familiar.

There is a potentially relevant Medicare waiver (Section 222) which would be important for serving dually eligible beneficiaries in a single LTC model. A freedom-of-choice waiver under Section 222 would allow mandatory Medicare beneficiary participation. A Section 222 waiver is necessary for full integration of Medicare with Medicaid funds, which is a design objective for the LTC models. HCFA appears reluctant to grant these waivers, though several other states have apparently been successful in negotiating some aspects of what is potentially available under these waivers

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# APPENDIX

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## LTC Models: Medicaid Covered Benefits

Covered Benefits	Current Availability
<b>I. Acute/Primary Benefits</b>	
A. Inpatient and outpatient hospital services	FFS/QHP
B. Emergency Services	"
C. Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)	"
D. Secondary Prevention	New
E. Chiropractic Services	FFS/QHP
F. Podiatry Services	"
G. Immunizations	"
H. Well child/EPSDT for persons under age 21	"
I. Transplant Services	"
J. Family Planning Services	"
K. Pharmacy Services	"
L. Durable Medical Equipment Orthotics, Prosthetics, & Shoe Supplies	"
M. Certified Nurse Mid-wife services	"
N. Certified Pediatric & Family Nurse Practitioner Services	"
O. Hospice Services	"
P. Transportation Ambulance & other Emergency Medical Transportation	"
Q. Vision services	"
R. Hearing & Speech services, including Hearing Aids	"
S. Therapies, (speech, language, physical, occupational)	"
T. Diagnostic Lab, X-ray, and other imaging services	"
U. Health Education	"
V. Enhanced/Wellness Benefits	QHP
W. Home Health Services	"
X. Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)	"
Y. Parenting & Birthing classes	"
Z. Medically necessary weight reduction services	"
AA. End Stage Renal Disease	"
BB. Mental Health care up To 20 outpatient visits per contract year	"
CC. Maternal & Infant Support Services (MISS). Outreach for included services, especially pregnancy related and well-child care	"
DD. Treatment for sexually transmitted disease (STD)	"
EE. Blood lead follow-up services for individuals under the age of 21	"
FF. Out of state services authorized by contractor	"
<b>II. Nursing Facility Benefits</b>	FFS
A. Administrative Services	"
B. Oral Hygiene Supplies	"

Covered Benefits	Current Availability
C. Durable Medical Equipment 1. Standard Equipment 2. Customized Equipment	"
D. Enrichment Programs	"
E. Food	"
F. Holding a Bed	"
G. Hospice	"
H. Intravenous Therapy--nursing services, supplies & equipment,	"
I. Laboratory tests which can readily be performed at the nursing home (e.g., Teststrip) the drawing and delivery of laboratory specimens	"
J. Laundry Services	"
K. Medical Supplies & Accessories	"
L. Medication Review	"
M. Mental Health Service provided by nursing staff	"
N. Nursing Care	"
O. One-Day Stay	"
P. Oxygen Administration, equipment, supplies	"
Q. Personal Hygiene Items	"
R. Pharmacy/Over the Counter Products (OTCs)	"
S. Special Placement (e.g., ventilator care)	"
T. Routine Maintenance Therapy	"
U. Transportation	"
V. Vaccines	"
<b>III. LTC Community Based Benefits*</b>	
<i>*All covered benefits may be provided in any community based residential setting</i>	
<i>*Self-directed care and individual budgets (for all or part of the services/supports to be provided) must be available to beneficiaries at their option.</i>	
A. Adult Day Care	MI Choice Waiver
B. Care Management	Home Help/FIA MI Choice Waiver
C. Chore Services	MI Choice Waiver
D. Counseling	MI Choice Waiver
E. Emergency Services	New
F. Environmental Modifications	MI Choice Waiver
G. Family/Caregiver Support Services	New
H. Fiscal Intermediaries	New
I. Home-delivered Meals	MI Choice Waiver
J. Homemaking Services	Home Help/FIA MI Choice Waiver
K. Hospice	FFS/QHP
L. In-home Nursing (including staff transportation) 1. Nursing, R.N. (hourly and visit) 2. Nurse, L.P.N. (hourly and visit) 3. Certified Nurses Aide (hourly and visit)	FFS, MI Choice Waiver
M. Multidisciplinary Assessments, as needed for the person centered planning process	New
N. Personal Care 1. Direct 2. Supervision	Home Help/FIA MI Choice Waiver
O. Personal Emergency Response Systems	MI Choice Waiver

<b>Covered Benefits</b>	<b>Current Availability</b>
P. Community Based Prevention	New
Q. Respite	MI Choice Waiver
R. Specialized Medical Equipment and Supplies	MI Choice Waiver
S. Training in Independent Living Skills	MI Choice Waiver
T. Transportation, non-medical	MI Choice Waiver
U. Other services determined necessary by the person centered planning process to improve and maintain the participant's overall health status	New
V. Optional at the plan's discretion, Room and Board Support	New
W. Optional, at the plan's discretion, Transportation/Community Living Subsidy Funds	New



## Medicaid New Covered Benefits Definitions

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### Community Based Emergency Services

*Definition:* LTC Community-based Emergency Services are those activities and services needed to respond appropriately to the crisis, emergency and/or urgent needs of the beneficiaries of a long term care plan, as related to their long term care and support in the community. Community-based emergency services must include a 24-hour, seven days per week crisis emergency service that is prepared to respond to individuals experiencing urgent and emergency situations. Services involve assessments, diagnosis, crisis intervention and/or rapid referral and linkage to needed care and resources. These services include, but are not limited to, outreach, capacity to place an individual in a safe, temporary environment if needed, and immediate deployment of in-home care staff. These services may be directly provided by the LTC plan, or may be arranged through contract.

(This is a separate benefit from the medical emergency options that occur in accordance with the provisions of the plan for emergency acute care.)

### Family/Caregiver Support Services

*Definition:* Family/Caregiver supports services are services provided to families and/or caregivers of persons who are elderly or have a long term physical disability for the purpose of maintaining a person in his/her home. Services include those designed to preserve family and caregiver capacity, prevent facility placement, and restore family/caregiver capacity.

Supports provided depend on the needs of the individual and the family/caregivers. They include, but are not limited to, education, training, and counseling for family members, and caregivers (parents, spouse, children, siblings, relatives, in-laws) who are caring for and/or living with a family member who is elderly or physically disabled. To the extent available, family/caregiver supports should coordinate and/or compliment other resources already available in the community.

(Respite services are listed as a separate covered benefit)

### Fiscal Intermediaries

*Definition:* Fiscal intermediaries are agencies or entities that provide the necessary administrative fiscal functions to support the consumer in having more direct control over selecting and supervising direct care workers and other services. These functions may include managing payroll, maintaining records, producing reports, purchasing fringe benefits and other fiscal and support services. A fiscal intermediary generally provides these services to the consumer, the funding organization and service providers.

## **Multidisciplinary assessments, as needed for the person center planning process**

*Definition:* Multidisciplinary assessments are those assessments needed to support an effective person centered planning process. Person centered planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities. As part of this process, assessments from a variety of disciplines and/or life areas may be necessary in order to clarify needs, abilities and appropriate service/support choices.

## **Secondary Prevention (an acute/primary covered benefit)**

*Definition:* Secondary prevention is those interventions that prevent the occurrence of secondary conditions and/or further deterioration of the disability/primary condition. Secondary disability/condition(s) are causally related to a disabling condition and can be either a pathology, an impairment, a functional limitation, or an additional disability. Examples of secondary conditions may include mobility problems, skin problems/pressure sores, arthritis, carpal tunnel syndrome, fatigue, weakness, pain, obesity, osteoporosis, depression and respiratory problems, etc. They can also include injuries from improper or lack of adaptive equipment and orthotic devices.

(It should be noted that removal of many current fee for service benefit restrictions in a capitated environment will allow any benefit to be used more flexibly. This will help ensure that proactive prevention can be maximized.)

## **Community Based Prevention**

*Definition:* Community based prevention is those activities, materials and processes that serve to assist individuals and/or groups of people covered by the plan from becoming ill, having increased difficulty with activities of daily living and/or instrumental activities of daily living, losing cognitive ability and/or jeopardizing the capacity of the individual to remain in a more independent community based setting.

## **Other services determined necessary by the personal centered planning process to improve and maintain the participant's overall health status**

*Definition:* As part of the person centered planning process, services and/or supports not otherwise included in the covered benefits list may be identified as being needed to improve and/or maintain the participant's health status and ability to live in their own home and community. These services/supports may be covered so long as they are included in the person-centered plan and their relationship to goals and objectives that address long term care issues and

for the person's ability to live in the community are identified. (This recognizes that a person-centered plan may contain components for which Medicaid is not able to provide coverage.)

### **Optional, at the plan's discretion, room and board support**

*Definition:* The plan may, at its discretion, offer financial subsidies for room and board on an individual basis if, by doing so, an individual may live in a more independent and less costly setting than would be the case if a subsidy were not available. Provision of this benefit is subject to use of the Community Residential Room and Board Support Practice Guideline. Using plan funds for this may occur only after all other resource options have been considered and found to be unavailable.

### **Optional, at the plan's discretion, Transition/Community Living Subsidy Funds**

*Definition:* These are funds that may be used for expenses that are necessary on an individual basis for a consumer's transition to a more independent living setting, but are not covered by other funding options. For example, a nursing home resident transitioning to community living may need assistance with a rental security deposit or housekeeping supplies. Provision of this benefit is subject to use of the Community Transitioning Support Guideline. Using plan funds for this may occur only after all other resource options have been considered and found to be unavailable.





## Medicaid and Medicare Covered Benefits Under PACE

Covered Benefits	
I.	Acute/Primary Benefits
A.	All Medicaid-covered services, as specified in the State's approved Medicaid plan
B.	Multidisciplinary assessment & treatment plan
C.	Primary care, physician and nurse services
D.	Social work services
E.	Restorative therapies, including physical therapy, occupational therapy and speech-language pathology services
F.	Transportation
G.	Medical Specialty Services
a)	Anesthesiology
b)	Audiology
c)	Cardiology
d)	Dentistry
e)	Dermatology
f)	Gastroenterology
g)	Gynecology
h)	Internal Medicine
i)	Nephrology
j)	Neurosurgery
k)	Oncology
l)	Ophthalmology
m)	Oral Surgery
n)	Orthopedic Surgery
o)	Otorhinolaryngology
p)	Plastic Surgery
q)	Pharmacy Consulting Services
r)	Podiatry
s)	Psychiatry
t)	Pulmonary Disease
u)	Radiology
v)	Rheumatology
w)	General Surgery
x)	Thoracic and Vascular Surgery
y)	Urology
H.	Laboratory tests, x-rays, other Diagnostic procedures
I.	Drugs & biologicals
J.	Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as: eyeglasses and lenses, hearing aids, dentures and repair and maintenance of these items.

## Covered Benefits

### K. Acute inpatient care, including:

- a. Ambulance
- b. Emergency room care and treatment room services
- c. Semi-private room & board
- d. General medical & nursing services
- e. Medical surgical/intensive care/coronary care unit
- f. Laboratory tests, x-rays, & other diagnostic procedures
- g. Drugs and Biologicals
- h. Blood and blood derivatives
- i. Surgical care, including the use of anesthesia
- j. Use of oxygen
- k. Physical, occupational, respiratory therapies, and speech-language pathology services

### II. Nursing Facility Benefits

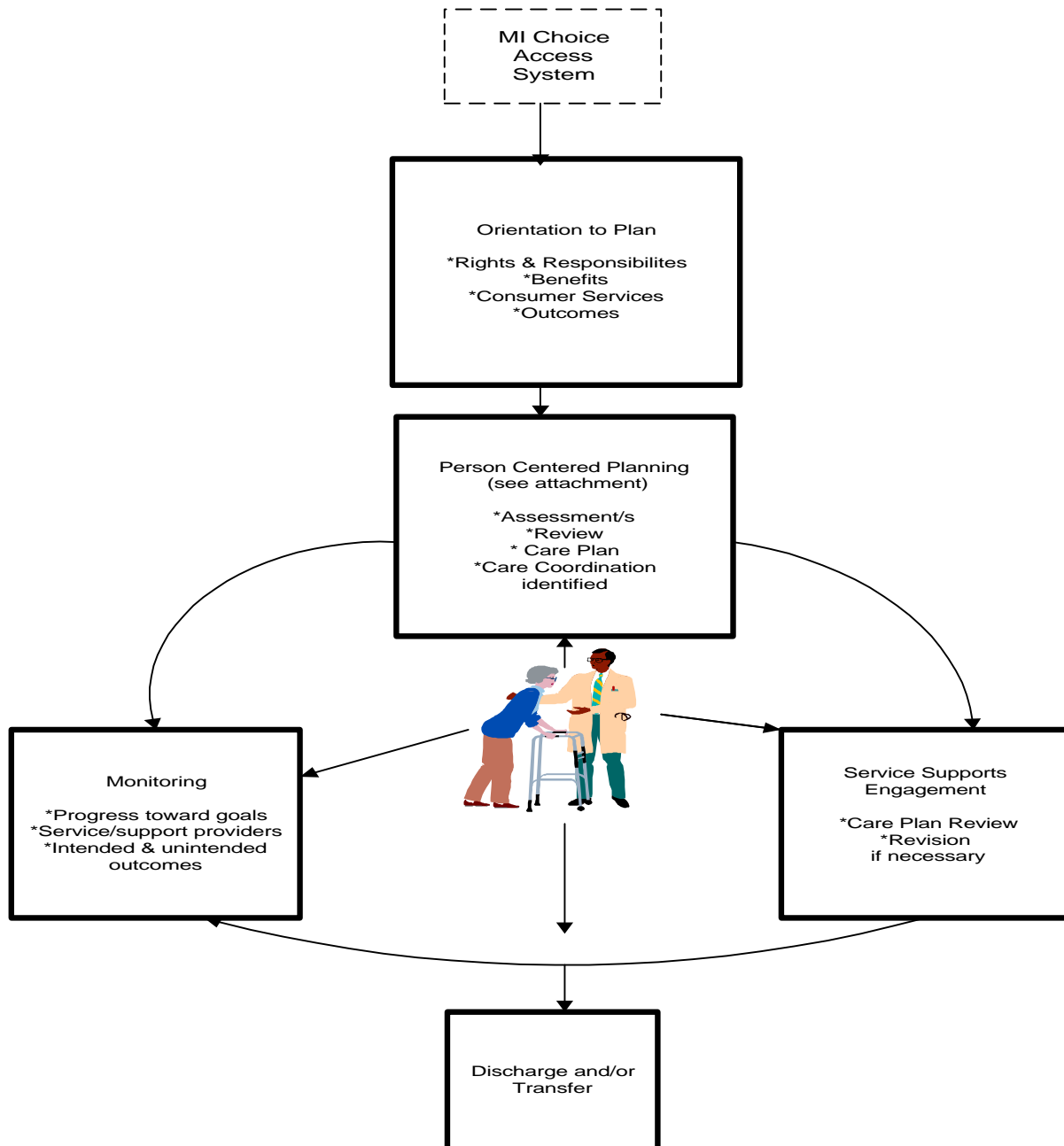
- A. Semi-private room & board
- B. Physician & skilled nursing services
- C. Custodial care
- D. Personal care and assistance
- E. Drugs and biologicals
- F. Physical, occupational, recreational therapies, and speech-language pathology, if necessary
- G. Social services
- H. Medical supplies & appliances

### III. LTC Community Based Benefits

- A. Personal care and supportive services
- B. Day Program
- C. Nutritional counseling
- D. Recreational therapy
- E. Meals
- F. Other services determined necessary by the multidisciplinary team to improve and maintain the participant's overall health status

# LTC Model Service Process Flow Chart

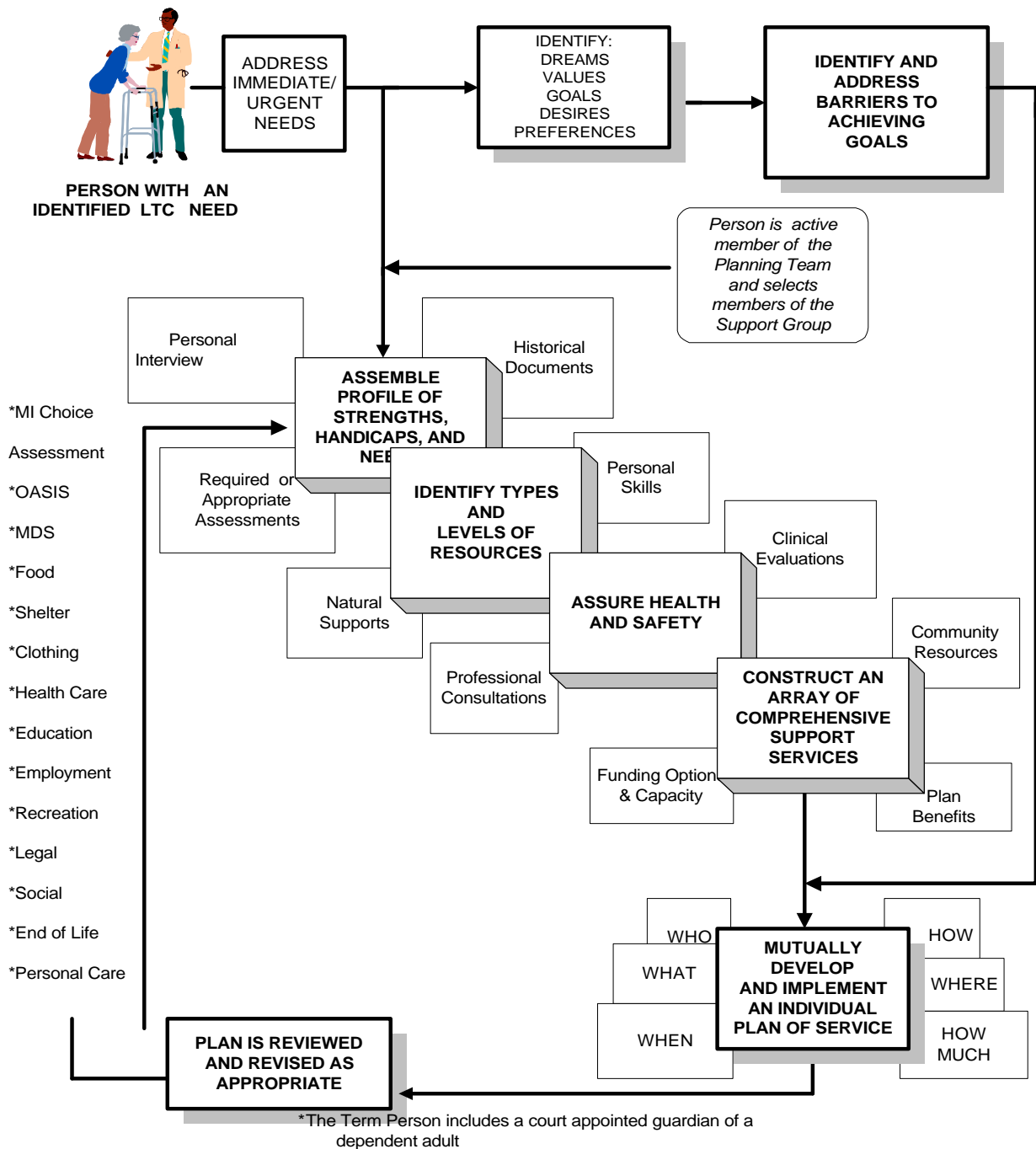
## LTC MODEL SERVICE PROCESS WITHIN A MODEL PLAN





# Long Term Care Person Centered Planning Flow Chart

PERSON CENTERED PLANNING FOR PERSONS\*  
WITH LONG TERM CARE NEEDS





# Financing Issues

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## Introduction

Moving to a new system of long term care service delivery, will require the creation of new financing structures. These financing structures must be integrated into the design process, so that the design objectives and the financing mechanisms are compatible. The design process has proceeded from the assumption that we will use existing financial resources in new ways. The new system will be built on the resources of the old system.

## Overview of Current Financing

The key service components of the current system are nursing facilities, the home and community based waiver services, home help, and medical services provided to those in long term care. In following sections, the financing mechanisms and considerations of each of these current subsystems are explained.

## Current Nursing Facility Financing

Nursing facilities are reimbursed using a prospective cost-based system within one of two classes. Class III is for county owned facilities and hospital-attached facilities. The rest of the facilities are in Class I. An individual facility's costs from a historical period are used to set a per diem rate for a current period. A facility submits a cost report every year. Cost reporting and auditing limit the reported costs to those that are allowable for Medicaid rate setting. For example, excess owner compensation costs are not included in Medicaid rates. The cost reporting process separates accounts into those associated with patient care and those that are administrative or for capital maintenance. Each of these categories and certain other cost categories are subject to reasonable cost limits. For example, variable costs associated with patient care costs above the 80th percentile for the class are imputed at the 80th percentile for rate setting purposes. Once a cost basis is arrived at for the historical period, it is brought forward to a payment year per-diem. The current inflation factor was legislatively mandated at 4 percent.

In addition to the basic rate there can also be rate add-ons. For several years facilities have been able to get a rate enhancement to fund wage and benefit increases for staff of fifty or seventy five cents an hour. These add-ons are cost settled to insure that increases are actually paid to workers. The most recent wage pass through has been paid in addition to any other inflation adjustment. Facilities have also received rate add-ons as incentives for quality. Currently nursing home rates are not case mix adjusted.

## Home and Community Based Waiver

The home and community based waiver agents are paid an administrative fee for program administration and care management. Services other than care management are billed through

the Medicaid fee for service system up to a cost ceiling. Waiver agencies are at risk for cost above the ceilings in a shared corridor arrangement with the State.

## **Home Help**

The Department of Community Health and the Family Independence Agency share the home help program. DCH has responsibility for policy and federal requirements. FIA operates the program. Care managers are FIA employees.

Under the home help program, the consumer arranges for his or her own care provider with assistance from the FIA care manager, if needed. FIA acts as fiscal intermediary. FIA issues checks to pay for those services through the model payment system. FIA also pays social security and unemployment for caregivers so the consumer does not have to deal with the issues related to it.

## **Conceptual Approaches to Financing**

Even though the current long term care financing system functions under a fee for service model there are different approaches possible. Approaches can be categorized as follows:

- Fee for service
- Expenditure targets
- Global budgets
- Capitation
- Self-determination service vouchers

Each of these approaches has advantages and disadvantages.

## **Fee for Service**

Under a fee for service system providers agree to participate and are paid when they submit a valid bill for a service provided. The more providers bill the more they are paid. The fee is often negotiated or determined by the Medicaid program. There can be limits on payment rates. The current nursing facility per diems are paid under fee for service but the rate determination process checks for allowable costs and imposes payment limits in setting that rate. Fee for service systems often have access controls for high cost services. For example, an expensive procedure may require prior authorization before it can be provided. Because the system contains no financial incentives to limit services, fee for services systems have post-payment utilization review to check for appropriateness of services.



## **Expenditure Targets**

Expenditure targets are non-binding budgets or capitation amounts calculated for a set of services. The targets are determined through the same kind of cost analysis that is used for risk bearing structures like capitation.

Expenditure targets are created where there is a managing entity for a set of health care services that can apply care management and other tools of managed care but the managing entity is not organized to bear risk. Services continue to be billed under a fee for service model. While not binding, the targets provide a way for the organizations and the payer to measure care management performance on a total cost basis as well as a way of examining and managing unit costs. Within an expenditure target system, payers can create incentives for meeting or exceeding targets.

## **Global Budgets**

Global budgets fix a set amount for all health care services in a geographic area. For example, in the Canadian health care system, provinces are given a fixed amount of money to provide all health care services to the population. If the funds are inadequate, the managing governmental unit must cut services or add money. Providers within the system are not necessarily at risk, but they have an interest in the yearlong solvency of the managing entity, usually a unit of government. The amounts paid are usually based on budgetary approaches. This means that the system has year-to-year corrections based on over or under expenditures but is not volume sensitive in the short run.

## **Capitation**

Capitation is the financing structure commonly used to pay for Health Maintenance Organization (HMO) services. Costs are calculated on per member per month basis. The rate is often adjusted for cost risk factors such as age and gender and geography so that there are different rates depending on consumer characteristics. Some capitation systems for high-risk populations adjust for the medical characteristics of the consumer. If rates are determined based on fee for service cost, they may be discounted to account for expected savings from managed care. Capitation rates are usually all-inclusive for a broad set of services. Services not included are sometimes called “carve outs”. Managing entities assume financial risk for providing services in excess of capitation payment amounts. They will be able to keep some or all of the efficiency gains as profit or community benefit.

The managing entity creates the network of providers of services and the payment arrangements. Network providers may or may not assume some of the risk for meeting financial constraints. If providers share in the risk, they also can make profit. Payers may have arrangements under a capitated system where the cost of expensive cases is shared or large profits are shared. Such arrangements are often structured around corridors. Because they are paid on a per consumer basis, capitation systems respond to volume changes, immediately.

## **Self-Determination Vouchers**

Vouchers are a way of giving consumers control over their lives. The consumer has a fixed budget and is responsible for arranging for and managing their services. Home health and personal care are kinds of services that are vouchered. In most places where vouchers have been put in place, support services are available to the consumer to assist them in managing their own care and to insure quality. In some places agencies act as the fiscal intermediary for the consumer, writing checks and taking care of insurance and liability issues. The consumer may or may not be at risk. However, if the consumer exceeds their budget they may lose the opportunity to manage their own care.

## **Why Capitation?**

Capitation has come to be an approach of choice in dealing with health care costs. The reason for this is the structure provides very strong cost controls. It creates strong incentives for cost control at the management and provider levels. The profit motive creates incentives for even more cost control that may be leveraged in future capitation amounts. The structure provides more flexibility in delivering services that improves consumer satisfaction, quality of service, and health outcomes. The cost pressure and the flexibility of the delivery structures encourage innovation and administrative efficiency. Capitation also provides incentives for preventive care.

For the payer, capitation creates a very predictable budget. The at-risk entity assumes most of the risk for fluctuating costs. If there are profit sharing features built into the capitation system, the payer may also realize savings. Capitation is responsive to population changes.

## **Conceptual Rate Setting Process**

A capitation rate is designed to pay a fair per member per month fee for a set of services. It is usually based on an analysis of fee for service data. Global budgets are set based on yearly-expected cost. Global budgets can be derived from the same kind of analysis that is used to develop capitation rates.

In order to set capitation rates, costs for the sets of services being capitated are divided by the number of people receiving services, adjusted to a monthly basis. Usually this is done for a base year period. Once the basic calculation is done refinements are made. Costs are analyzed to see how much they vary based on age, gender, geography, and acuity. Overall adjustments are made to account for inflation trends and program changes that affect cost. Refinements can be made to the basic calculation or by creating rate cells based on age, geography or acuity if the cost analysis indicates it is necessary. Capitation rates are usually done under the supervision of an actuary and are examined for actuarial soundness.

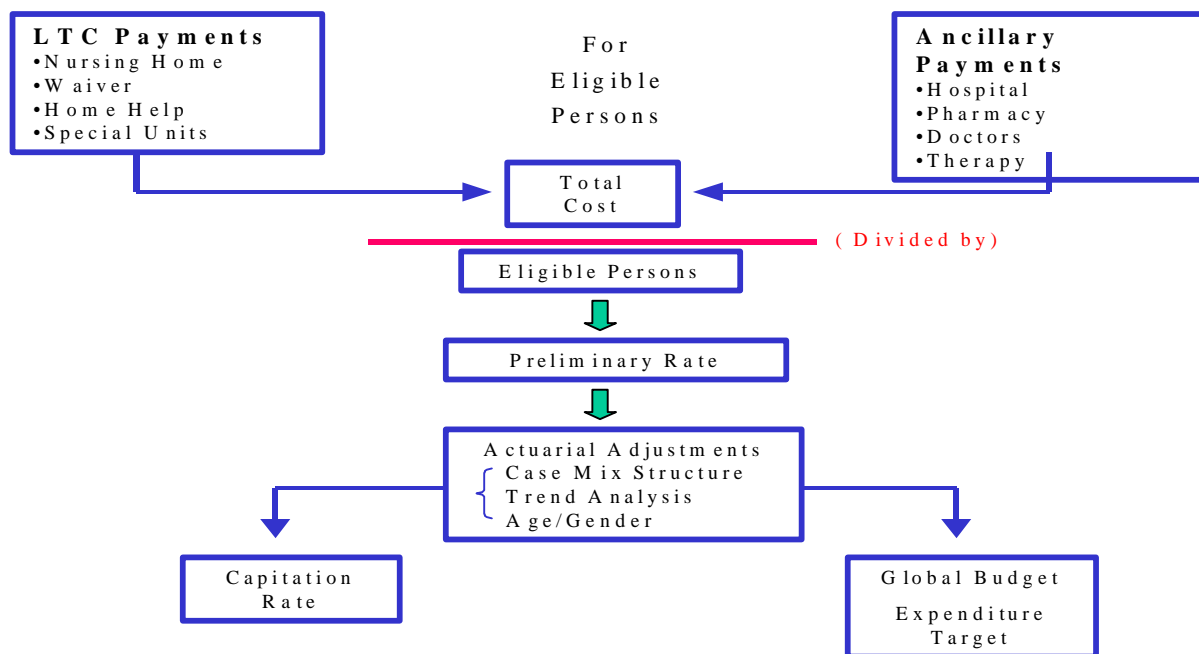
## **Fund Sources**

The new long term care delivery systems are expected to reduce fragmentation in the system by integrating funding sources. The following funding sources will be integrated to the extent possible:

- Aging
- Medicaid
- Private insurance
- Private buy-in
- Medicare

Medicaid funding will be comprised of funds currently used to pay for nursing facility care, home and community based waiver service, ancillary medical care, home help services, and amounts Medicaid consumers contribute toward their care costs.

### Medicaid Rate Development for LTC Medicaid Costs Rates



## **Case Mix**

It makes intuitive sense that different consumers have different care needs and different associated costs. Case mix systems adjust for acuity in the amounts paid for services. In long term care the most prevalent systems create categories for payment based on information contained in the federal Minimum Data Set (MDS). The MDS is a comprehensive assessment tool that contains information on a consumer's diagnosis, support systems, and their ability to perform a core set of functions associated with independent living.

One advantage of case mix adjusted systems is that they remove from at risk plans both incentives and disincentives related to care needs of potential consumers. All consumers are equally attractive based on the relationship between need for services and payment. People who need more services come with increased payment. Those who come with lower care needs come with lower payment.

Financing in the new system will account for case mix differences in payment.

## **Risk Sharing**

In creating financing for the new models risk-sharing mechanisms are often used to encourage implementation. For example: In the first two years of operation of a Regional Provider Organization the State will share some percent of costs exceeding an agreed to level.

In order to protect the at-risk entity and service to consumers, organization must have reinsurance and cash reserves.

## **PACE Financing Structure**

There is already one Program of All Inclusive Care for the Elderly (PACE) in Michigan. This plan is financed under a dual capitation model. The federal government provides a capitation for Medicare service payments and the State provides a capitation reflecting Medicaid fee for service experience for this population. This system will be maintained in Phase I.

## **LTC-HMO Financing Approach**

Because HMO structures are a business model based on capitation and risk, this model will be capitated at onset of Phase I implementation. The model will be implemented through a competitive bid for services and rates. There will be multiple providers in an area. In setting the capitation rates, rate cells will be established that have adjustments for geography and case-mix. In the initial implementation period the State may engage in some risk sharing with the at-risk plans. No explicit start-up costs will be recognized.

## **Care Coordination Model Financing Approach**

Because the Care Coordination Model is based around the existing waiver structure, which incorporates ceilings and limits, the long term care component of this model will be capitated at onset of Phase I. Capitation of acute/primary care will be phased in. The model will be

implemented through a competitive bid for services and rates. There will be multiple providers in an area. In setting the capitation rates rate cells will be established that have adjustments for geography and case-mix. In the initial implementation period, the State may engage in some risk sharing with the at-risk plans. Because managing acute/primary care will be new for waiver agencies, the state will consider supporting development through technical assistance and other needs.

## **Regional Provider Organization (RPO) Financing**

Because Regional Provider Organizations are based in a community-organizing model and will have to be developed, they will start with expenditure targets under fee for service and move to capitation arrangements with risk corridors after a reasonable period of implementation experience. This may be two or three years. Eventually, the RPOs will assume full risk within a case mix adjusted capitation rate.

Because it requires community organizing, the State will support development through technical assistance and other means.

## **Virtual Organization Financing**

The virtual organization is an emerging way of delivering goods and services in business but has not been widely used to deliver public services. The virtual organization is expected to follow system development processes that begin with a prototype that is refined through formal testing processes. For this reason it will be run initially under fee for service using expenditure targets to track ongoing performance in real time. Start up and development may be supported by a State/private sector partnership. The model will move to full risk capitation over time. This model will incorporate consumer directed vouchers for a subset of service.

## **Start-up Costs**

Most of the start-up costs will be borne by the organizations and businesses bidding. Services, profit, and administration will come out of existing funds spent for services under the fee for service model. However, there are a few explicit State start-up costs. They are:

- Technical assistance
- Infrastructure, i.e. information systems
- LTC model management and monitoring

Technical assistance will be necessary for all of the models but for the RPO and Virtual Organization in particular. Some of the infrastructure to enable all of these models may have to be supported. Information systems such as an encounter data reporting system in particular will be needed. Wherever possible infrastructure will be built on top of existing systems. Finally, putting Phase I into operation and monitoring the plans on an ongoing basis will require State staff and other resources.

## **Quality Incentives**

A quality incentive system for the LTC models based on outcomes will be used. Outcome-based systems like those developed or under development by David Zimmerman of University of Wisconsin, Brant Fries of the University of Michigan, John Morris of Harvard University, and others, will be the framework for this system. Quality incentives would be a reward system related to profit or payments and only paid after a period of sustained quality performance.

## **Structures for Long Term Care Model Organizations**

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There are three different structures that might be used in the proposed long term care models: Health Maintenance Organizations (HMOs), Alternate Health Care Financing and Delivery Systems (AFDS), and Provider Sponsored Organizations (PSOs). The three structures are related and yet have their unique features.

HMOs and AFDS are licensed by the State as governed by the Public Health Code. Licensing responsibility is currently shared between the Department of Community Health and the Insurance Bureau. However, the DCH responsibilities are in the process of being move to the Insurance Bureau.

### **HMO**

HMOs are organizations that go at risk for a full range of health and medical services. In order to be an HMO the entity must meet state licensure requirements including adequate risk bearing structures and provide at least “primary health care services” as defined in the law. Primary services are:

- Physician services
- Ambulatory services
- Inpatient hospital services other than for treatment of mental illness
- Emergency health services
- Diagnostic and laboratory and radiological services and therapeutic radiological services
- Preventive health services

HMOs can add any service above the primary and basic services, but not provide fewer. The Medicaid medical services we are including in the models encompass the required primary services. Therefore as long as the Medicaid medical component is required for implementation, all of the proposed models could add long term care services and be licensed as HMOs. Since some of the models will likely phase in medical services after long term care services are established, these models would not initially be licensed as an HMO.

### **Alternative Health Care Financing and Delivery Systems (AFDS)**

The public health code also contains provisions for licensing of alternate financing and delivery systems. This structure provides the Insurance Bureau and the Department the

flexibility to create managed care organizations that provided fewer or different services than HMOs.

AFHDs are not allowed to call themselves HMOs but have cash reserve and reinsurance and other risk requirements. So far licenses issued for AFDS have been for single provider types such as dental or vision services, but the law does not require this.

## **PSO**

Provider sponsored organizations are a federal structure that was created by the Balanced Budget Act of 1997. A PSO is a health care delivery network that is owned and operated by providers who have the ability to provide 70 percent of the care needed by members. The structure has lower capital requirements than are required of Michigan HMOs though reserves and capital requirement are still substantial. PSOs are required to meet state HMO licensure requirements within three years, though HCFA can waive this requirement. Most likely PSOs will be licensed as HMOs.



## **Impact on Current Providers**

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### **LTC HMO Model**

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In the HMO model, the HMO is the entity at risk and responsible for putting together a network of providers who provide ready access to all components of the Medicaid benefit design. It is the HMO's responsibility as to which providers it includes in its provider panel. Clearly it must have nursing homes in its provider panel, however it is not required to include all nursing homes in a given community in its provider panel.

Care management is a required component of the HMO service array. Presently care management services are provided by waiver agents. The HMO may contract with these existing organizations to provide the care management services but would not be required to do so. It would however, need to demonstrate, through a combination of its management resources and its provider panel, expertise in each of the long term care target populations: non-elderly people with disabilities, frail elderly, Alzheimers and related dementia, end of life.

Presently waiver agents “pay the bills” of providers who deliver home and community based waiver services. This responsibility would move to the HMO. An HMO could sub-contract with a waiver agent to perform these functions, but would not be required to do so.

A portion of the personal care services benefit is presently managed by local Family Independence Agency (FIA) offices. This benefit (including the ability to directly hire their own aide and attendant staff) would continue under the HMO model and the HMO would be responsible for making this service available. If they chose they could contract with the local FIA office to case manage this benefit but they would not be required to do so.

Acute care providers—primarily hospitals and physicians will also need to be a component of the HMO's provider network. Again, the HMO will not be required to include all of the acute care providers who operate in that area on its provider panel. Medicaid covered people who are currently enrolled in Qualified Health Plans for their acute care will be transferred to the LTC HMO when they apply for long term care services so that both their acute and long term care Medicaid services will be managed and coordinated by the same HMO.

### **RPO Model:**

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The RPO is a partnership model comprised of local service providers. Typically these providers will form a joint venture organization that will serve as the managing entity for the organized integrated service delivery system. The partners would “co-own” this joint venture organization. While the partnership must include organizations that have experience with each of the target populations, including the acute care component, it does not need to include literally every provider that exists in that community. And some providers may be contracted components of the provider network without needing to be an owner partner in the RPO. (Some local providers, such as those whose auspices are governmental, may not be eligible to be owner-partners, but can be included in the provider network as contracted providers.)

So---current nursing homes can be members of the RPO as can current waiver agents and hospital and physician providers. The personal care benefit managed by FIA would be a component of the benefits provided to enrollees in the RPO and the RPO could contract with FIA to manage this benefit but would not be required to do so. The RPO's joint venture organization could subcontract with existing entities, such as waiver agencies to provide certain administrative services rather than creating new capacity to do so. Or the waiver agent's capacity could be transferred to the RPO. Similar arrangements can be made with other current providers. The RPO could even enter into an administrative services contract with an HMO to provide billing or other infrastructure services even though the HMO would not be involved in the RPO in any other way and would not be at risk in any way.

### **Care Coordination Model:**

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The administering entity of the Care Coordination Model is a waiver agent. The waiver agent is responsible for enrolling a comprehensive provider network to provide the full array of covered Medicaid services in an accessible fashion. It will contract with nursing homes, home health providers, hospitals and physicians. It will not be required to contract with all existing providers but it may if it chooses to do so. Again, the personal care benefit managed by FIA will be a component of the long term care services. The Care Coordination Agency can contract with the local FIA office to manage this benefit but would not be required to do so.

### **Virtual Organization**

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Some organization, either a single organization or through a joint venture operation, will be the managing entity for the VO. It will be responsible for enrolling a comprehensive provider network to provide the full array of covered Medicaid services in an accessible fashion. It will contract with nursing homes, home health providers, hospitals and physicians. It will not be required to contract with all existing providers but it may if it chooses to do so. Again, the personal care benefit managed by FIA will be a component of the long term care services. The VO can contract with the local FIA office to manage this benefit but would not be required to do so.

# **Tobacco Settlement**

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## **One-Time-Only Funding: LTC Innovations Spending Plan**

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### **Background:**

The legislature allocated \$10 million from the Tobacco Settlement Funds for one-time funding for functions and activities associated with the LTC Work Group Report and Recommendations. This was referenced in the Preliminary Report and some people made suggestions as a part of the public input process regarding activities they thought should be funded. No specific request for proposals has been made. Some organizations and groups have submitted proposals for funding, however responding to those specific proposals seems premature and potentially unfair to other organizations who may have an interest as well. This plan calls for the distribution of the \$10 million for specific areas. Which organizations will actually carry out these functions and the specificity of the projects will be determined later through an RFP-type process. The amounts designated for each area are general approximations. It is intended that the Department of Community Health will have the ability to make the final decisions on the disbursement of these funds based on the funding requests received and its judgement.

### **A. Goals**

1. Address priorities outlined in the LTC Group report and recommendations.
2. Support development of the models for an accessible and high-quality, managed long term care system.
3. Have potential for statewide impact.
4. Support activities which can be completed with one-time-only funding.

### **B. Funding Period**

Funding amounts included in the plan reflect the total amount of funding to be spent. The funds will be spent through a work project, meaning that they do not need to be spent before the end of the current fiscal year.

### **C. Funding Proposals**

1. A Long Term Care System improvements-implementing the models – Total Estimate: \$2 million

- a. LTC Models Evaluation -\$500,000
- b. Develop evaluation design for long-term care models
- c. Conduct evaluation
- d. Design consumer report cards for LTC models
- e. Design and conduct evaluation of other innovation projects
- f. Virtual Organization development - \$500,000
  - Develop tools and technology in cooperation with a private partner.
  - Systems design
  - Wide band access and other technology items.
- g. Regional Provider Organization - \$500,000
  - Technical assistance and community organizing needed for this model
- h. Care Coordination Model-\$500,000
  - Technical assistance to assist existing waiver agents in developing the capacity to manage the full range of Medicaid long-term care and acute and primary services.

(No start-up funding will be needed to implement the HMO Model.)

2. Long Term Care Staff Development and Training - Total Estimate - \$2.025 million

- a. Support development of innovative staff retention programs including such things as Eden Programs and membership in the National Association of Geriatric Nursing Assistants . \$800,000.
- b. Identify and disseminate best practices for attracting and retaining direct care staff - \$500,000
- c. Create capacity to develop collaborative effort between colleges, community colleges, Department of Career Development, Department of Community Health, Department of Consumer and Industry Services and long term care providers to undertake a recruitment campaign aimed at creating a future pool of direct care workers for long term care. Provide opportunities for direct care workers, managers and administrators who work in long term care to improve the workplace and enrich work life for all. Develop skills staff need to assist consumers in the long term care system to achieve and maintain a better quality of life. Revise CENA Training Program.
- d. Collaborative Training Programs to improve care of individuals with difficult to manage behaviors for workers, communities and family care-givers in all components of the long term care system - \$375,000
- e. Project to determine whether early intervention and use of volunteers affects Medicaid use-\$350,000

3. Community Education Efforts - Total Estimate: \$375,000

- a. Collaborative community education programs on successful aging. Replicate Calvin College/Grand Rapids Community College Consortium on Successful Aging.
4. Innovation Projects For the Elderly and Disabled - Total Estimate: \$ 5.6 million
- a. These funds will be used for innovative program efforts in a variety of areas carried out in communities. Preference will be given to communities where the long-term care models are initiated. An RFP process will be used to allow organizations and groups to submit proposals. Proposals will be judged according to the following criteria:
    - Adherence/reflection of the Guiding Principles established by the Long Term Care Work Group
    - Demonstrated relationship to the Current Challenges established by the Long Term Care Work Group
    - Relationship to one or more of the models.
    - Potential for sustainability over time
    - Potential for broader application, integration into long term care reform
  - b. Specific categories in which proposals will be sought include:
    - Caregiver education, support and training
    - Innovative efforts associated with the integrated service delivery models
    - Efforts to enhance access to affordable housing for elderly and disabled who need long term care and desire a community setting
    - Projects which promote personal responsibility and/or public private partnerships
    - Start-up related expenses for the long term care model in a specific community
    - Innovative uses of technology
    - Cooperative project regarding technical assistance to facilities with difficulty managing residents with abusive and/or disruptive behaviors

\*\$206,500 was previously allocated from this category for a one year continuation of the nursing home transition project through the Michigan Centers for Independent Living.

## **Ongoing Funding: Public Information and Education**

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### **Public Information and Education      \$3 million**

\$3 million from the Tobacco Settlement funds is available for Public Information and Education efforts. These funds are intended to be on-going. The general plan for the use of these funds is:

### **Staff capacity for the Office of Services to the Aging      \$300,000**

The boilerplate for this \$3 million appropriation specified that a portion of these funds would be allocated for 3 FTE staff positions at the Office of Services to the Aging. They will be devoted to efforts and activities relating to managing elements of the long term care program. This will include the capacity to direct and oversee the public information and promotion efforts and the MI Choice Access program. Funds will be allocated for these staff positions and related expenses.

### **Public Information and Promotion      \$2.7 million**

Approximately \$2.7 million will be used for a public awareness campaign regarding the need to plan for long term care. Public information will also be distributed through radio, TV and printed materials regarding how to access information about local long term care services. Public information campaigns directed at families and friends who are care-givers will also be initiated. A campaign to inform employers about the need for long term care planning and inclusion of long term care insurance in their benefit package can also be carried out.

## **Proposed Timetable for Long Term Care Implementation**

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May 2000	Boilerplate discussed for DCH indicating the future of the Long Term Care Work Group
June 5, 2000	Long Term Care Work Group adopts Long Term Care Report and Recommendations and submits the report to the legislature.
June, July, August 2000	Information about the Long Term Care Report and the Long Term Care Models are disseminated throughout the state. <ul style="list-style-type: none"> <li>▪ Report recommendations requiring legislative action are identified.</li> <li>▪ Discussions with Health Care Financing Administration</li> <li>▪ DCH solicits proposals for the \$10 million innovation funds</li> <li>▪ Public education and information campaign designed and initiated</li> <li>▪ Report recommendations to be implemented administratively are identified.</li> </ul>
September 2000	Legislature convenes.
November/December 2000	Legislation introduced that reflects the recommendation of the LTC Report.
December 2000	DCH solicits proposals from organizations desiring to manage one of the proposed LTC Models.
January 2001	LTC Work Group meets to receive an update.
March 2001	DCH selects organizations to manage the models in Phase I.
July 2001	LTC models initiated – Evaluation standards established.
January 2002	LTC Work Group meets to receive an update.
October 2002	Evaluation of LTC models initiated. A work group convenes to review LTC Report and issue an update and review recommendations for the future. Initiate Phase II of the models.

